# MEDICAL EXAMINATION CERTIFICATE

I certify that I have examined_____ in accordance with the requirements in Rule 14-90.0041, Florida Administrative Code, and referenced FDOT Form 725-030-11, and with knowledge of driving duties, I find that this person:

Note certification status here and on the medical examination form.

| | If applicable, only when: |
|---|---|
| ☐ MEETS STANDARDS (RE-EXAMINE IN 2 YEARS) | ☐ Corrective Lenses |
| ☐ DOES NOT MEET STANDARDS | ☐ Wearing hearing aid |
| ☐ MEETS STANDARDS, BUT PERIODIC EVALUATION REQUIRED | ☐ Temporarily disqualified due to: |
| DRIVER IS QUALIFIED ONLY FOR: | |
| ☐ 3-MONTHS ☐ 6-MONTHS ☐ 1 YEAR ☐ OTHER | |
| Return to medical examiner's office for follow-up on _____ | |

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachments embodies my findings completely and correctly, and is on file in my office.

| | | |
|---|---|---|
| Medical Examiner's Signature: | Telephone: | Date: |
| Medical Examiner's Name: (Print) | Medical Examiner's License or certificate number | |
| | Issuing State: | |
| | ☐ MD ☐ DO ☐ Physician Assistant ☐ Advanced Registered Nurse Practitioner | |
| Office Address: (Print) | | |
| CITY COUNTY STATE ZIP | | |
| Name of Driver: (Print) | Driver License No. | Issuing State: |
| Signature of Driver: | | Date: |