

Please keep this card
for your record do not
mail to the DMV.

MEDICAL EXAMINER'S CERTIFICATE

B-328 Rev. 10-2008

STATE OF CONNECTICUT - DMV

On The Web At ct.gov/dmvI CERTIFY THAT I HAVE EXAMINED *(Print Name of Individual Below)*

In accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

- | | |
|--|--|
| <input type="checkbox"/> Wearing Corrective Lenses | <input type="checkbox"/> Driving within an exempt intracity zone (49 CFR 391.62) |
| <input type="checkbox"/> Wearing Hearing Aid | <input type="checkbox"/> Accompanied by a Skill Performance Evaluation Certificate (SPE) |
| <input type="checkbox"/> Qualified by operation of 49 CFR 391.64 | <input type="checkbox"/> Accompanied by a _____ waiver/exemption |

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

SIGNATURE OF MEDICAL EXAMINER X		TELEPHONE NUMBER	DATE
NAME OF MEDICAL EXAMINER <i>(Please Print)</i>		ISSUING STATE	MEDICAL CERTIFICATE EXPIRATION DATE
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO.		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Physician <input type="checkbox"/> Advanced <input type="checkbox"/> Chiropractor Assistant Practice Nurse	
SIGNATURE OF DRIVER X		DRIVER'S LICENSE NUMBER	STATE
ADDRESS OF DRIVER			