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Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

5m 11/11/25
EE 3/10/25

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)

PERSONAL INFORMATION

Last Name: Jenkins First Name: Nenka Middle Initial: L Date of Birth: 06/02/72 Age: 52
Street Address: 100 Shephards Ln. apt 114 City: Totowa State/Province: NJ Zip Code: 07052
Driver's License Number: J25465887356722 Issuing State/Province: NJ Phone: (862) 450 6060
Email (optional): *nerikaj72@gmail.com CLP/CDL Applicant/Holder*: ☒ Yes ☐ No

Driver ID Verified By**: DRIVER LICENSE

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ☐ Yes ☒ No ☐ Not Sure

CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below.

☐ Yes ☒ No ☐ Not Sure

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below.

☐ Yes ☒ No ☐ Not Sure

(Attach additional sheets if necessary)

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Last Name: Jenkins First Name: Nerika DATE OF BIRTH: 06/02/1972 Exam Date: 02/13/25

IV. DRIVER HEALTH HISTORY (continued)

Do you have or have you ever had:	Not				Not		
	Yes	No	Sure		Yes	No	Sure
Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Seizures/epilepsy	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Eye problems (except glasses or contacts)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Ear and/or hearing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Lung disease (e.g., asthma)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Stomach, liver, or digestive problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Diabetes or blood sugar problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Insulin used	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Fainting or passing out	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Other health condition(s) not described above: ☐ Yes ☒ No ☐ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: ☐ Yes ☒ No ☐ Not Sure

(Attach additional sheets if necessary)

IV. DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: Nerika Jenkins Date: 02/13/25

SECTION 2. Examination Report (to be filled out by the medical examiner)

IV. DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

unremarkable

(Attach additional sheets if necessary)

Last Name: Jenkins First Name: Nenka DOB: 06/02/72 ^{DATE OF BIRTH} Exam Date: 03/13/25

STING

Use Rate: 78 Pulse rhythm regular: ☒ Yes ☐ No Height: 5 feet 1 inches Weight: 162 pounds ☒

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
ting	<u>91</u>	<u>58</u>	Urinalysis is required. Numerical readings must be recorded.	<u>1.030</u>	<u>N</u>	<u>N</u>	<u>N</u>
cond reading (optional)							
Other testing if indicated				Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.			

BMI 31 "6 days sleepier"

Vision
Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity

	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/ <u>20</u>	20/ <u>20</u>	Right Eye: <u>90</u> degrees
Left Eye:	20/ <u>20</u>	20/ <u>20</u>	Left Eye: <u>90</u> degrees
Both Eyes:	20/ <u>20</u>	20/ <u>20</u>	

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors ☒ Yes ☐ No

Monocular vision ☐ Yes ☒ No

Referred to ophthalmologist or optometrist? ☐ Yes ☒ No

Received documentation from ophthalmologist or optometrist? ☐ Yes ☒ No

Hearing
Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☒ Neither

Whisper Test Results

Record distance (in feet) from driver at which a forced whispered voice can first be heard	Right Ear	Left Ear
	<u>5</u>	<u>5</u>

OR

Audiometric Test Results

Right Ear:	Left Ear:
500 Hz	500 Hz
1000 Hz	1000 Hz
2000 Hz	2000 Hz
Average (right):	Average (left):

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
General	<input checked="" type="radio"/>	<input type="radio"/>	8. Abdomen	<input checked="" type="radio"/>	<input type="radio"/>
Skin	<input checked="" type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input checked="" type="radio"/>	<input type="radio"/>
Eyes	<input checked="" type="radio"/>	<input type="radio"/>	10. Back/spine	<input checked="" type="radio"/>	<input type="radio"/>
Ears	<input checked="" type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input checked="" type="radio"/>	<input type="radio"/>
Mouth/throat	<input checked="" type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input checked="" type="radio"/>	<input type="radio"/>
Cardiovascular	<input checked="" type="radio"/>	<input type="radio"/>	13. Gait	<input checked="" type="radio"/>	<input type="radio"/>
Lungs/chest	<input checked="" type="radio"/>	<input type="radio"/>	14. Vascular system	<input checked="" type="radio"/>	<input type="radio"/>

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: Jenkins First Name: Nenka DOB: 06/02/72 Exam Date: 03/13/25

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

Does not meet standards (specify reason): _____

☒ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate

Meets standards, but periodic monitoring required (specify reason): _____

Driver qualified for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ other (specify): _____

☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption (specify type): _____

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate

☐ Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)

Determination pending (specify reason): _____

☐ Return to medical exam office for follow-up on (must be 45 days or less): _____

☐ Medical Examination Report amended (specify reason): _____

(if amended) Medical Examiner's Signature: _____ Date: _____

Incomplete examination (specify reason): _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: [Signature]

Medical Examiner's Name (please print or type): DR. LAUREEN LONGO

Medical Examiner's Address: 60 JACOBUS AVE. City: KEARNY State: NJ Zip Code: 07032

Medical Examiner's Telephone Number: 551-253-7438 Date Certificate Signed: 02/13/25

Medical Examiner's State License, Certificate, or Registration Number: 38ML00746500 Issuing State: NJ

MD ☐ DO ☐ Physician Assistant ☒ Chiropractor ☐ Advanced Practice Nurse

Other Practitioner (specify): _____

National Registry Number: 3828314980

Medical Examiner's Certificate Expiration Date: 02/13/28

DOT CDL PHYSICALS LLC
60 JACOBUS AVE 2ND FL
KEARNY, NJ 07032
551-253-7438