DMV
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Commercial Medical/Vision Waiver Evaluation and Application

Please fill out each page in its entirety, incomplete applications will be rejected.

This application packet is to be completed by the applicant and a licensed physician prior to submitting to the Department of Motor Vehicles.

Applicant to complete this section:

Please indicate which office you would like your waiver information to go to:
☐ Sparks CDL ☐ Donovan CDL

Daytime Telephone Number: _____

Full Legal Name: _____

Physical Address: _____

Mailing Address (if different than physical): _____

Date of Birth: _____ Social Security Number: _____

Driver License Number: _____ License State: _____

How long have you been licensed to drive a commercial motor vehicle? _____

	Yes	No
Do you currently have a commercial driver's license?	☐	☐

If Yes, Which class of license do you hold? ☐ A ☐ B ☐ C

Endorsements: ☐ T ☐ N ☐ H ☐ X ☐ P ☐ S

If No, Which class of license are you applying for? ☐ A ☐ B ☐ C

Do you intend to carry passengers or haul hazardous materials? ☐ Yes ☐ No

Have you had any of the following in the past 3 years:	Yes	No
Suspensions or revocations for the operation of any vehicle, including your personal vehicle?	☐	☐
Involvement in a reportable accident for which you received a conviction for a moving violation.	☐	☐
Conviction for a disqualifying offense or more than one serious traffic violation while driving a commercial motor vehicle, which disqualified or should have disqualified your from operating a commercial motor vehicle under the provisions of 49 CFR 383.51.	☐	☐
More than two convictions for any other moving traffic violations in commercial motor vehicle.	☐	☐

I certify that all statements on this application are true, and I otherwise meet all qualifications under Federal Regulation for commercial licensure. I agree and understand that any statement of facts may cause the cancellation of my waiver. ***I understand that I must obtain a commercial driver license physical as required by the Federal Motor Carrier Safety Administration. This application does not supersede nor replace the required DOT physical.***

Applicant Signature: _____ Date: _____

Signatures must be originals. Photocopies are not acceptable.
Changes may not be made to this form once it is signed.

Applicant Name:_____ DL#:_____

To be completed by Motor Carrier/ Employer or Self-Employed Driver

Who is completing the following information: ☐ Motor Carrier ☐ Driver ☐ Self-Employed Driver

Company Name: _____

Company Address: _____

Company Contact Name and Phone Number: _____

Describe the type of operation the driver will be employed to perform: _____

What is the average period of time the driver will be on duty per day? _____ Hours Per Day

Duty Hours: _____ to _____ Daytime Driving Hours: _____

Nighttime Driving Hours: _____

What type of vehicle will the driver be operating: ☐ Straight Truck ☐ Tractor/Trailer Combination

Transmission Type: ☐ Automatic ☐ Standard ☐ Other

Number of Forward Speeds: _____ Real Axle Speed: _____ Single: ☐ 1 ☐ 2

Braking System: ☐ Air ☐ Hydraulic Type of Steering: ☐ Manual ☐ Power Assisted

Describe any modifications made to the vehicle to accommodate the driver's needs: _____

_____

Type of Driver Operation (sleeper-team, relay, owner-operator) _____

I certify that I have evaluated the driver named on this application:

☐ **For non-driving safety related job tasks associated with the type of trailer used; and**

☐ **For other safety related or job related tasks unique to the operations of employment.**

I further certify that the driver will only be used to operate the type of motor vehicle defined by the waiver and only when the driver is in compliance with the conditions and restrictions of the waiver.

Employer Signature: _____

Print Employer Name: _____

Date Certification Made: _____

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Applicant Name:_____ DL#:_____

Medical/Vision Evaluation

Waiver Restrictions:

- *Nevada Medical / Vision Waiver holders will be restricted to operating a commercial motor vehicle on an intrastate basis only.*
- *A medical waiver will not be issued to an applicant if they have suffered any fainting or dizzy spells, seizures or other similar disorders in the preceding 1 year.*
- *Applicants for a Nevada waiver are prohibited from holding an endorsement to operate passenger vehicles (P) or a vehicle used to transport hazardous materials (H) NAC 483.8012. Applicants may apply for a federal variance issued by the Federal Motor Carrier Safety Administration to operate passenger vehicles (P) or a vehicle used to transport hazardous materials (H).*

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1. Identify and describe the visual or physical impairment of the applicant: _____

2. Is the applicant's condition stable or progressive? ☐ Stable ☐ Progressive

3. Will this condition affect the patient's ability to drive a motor vehicle safely?
   ☐ Yes ☐ No If **Yes**, please explain: _____

4. Under your current prescribed treatment, can the patient safely operate a motor vehicle?
   ☐ Yes ☐ No If **No**, please explain: _____

5. Medications prescribed (please give type and dosage) _____

6. Will these medications affect the patient's ability to operate a motor vehicle safely?
   ☐ Yes ☐ No If **Yes**, please explain: _____

7. If the nature of the condition indicates loss / lapse of consciousness, seizure activity, fainting or dizzy spells, please indicate the date of the last occurrence: _____

   Nevada Administrative Code 483.8031 prohibits the operation of a commercial motor vehicle if the applicant has suffered any fainting or dizzy spells, seizures or other similar disorders during the previous one year.

   7a. Was the seizure or loss of consciousness an isolated incident? ☐ Yes ☐ No

   7b. Are additional seizures likely to occur? ☐ Yes ☐ No

Applicant Name:_____ DL#:_____

8. I have examined the above-named applicant and offer the following record of eye examination:

	Without Rx	With Current Rx	With New Rx If being Changed
Right eye	20/	20/	20/
Left eye	20/	20/	20/
Both eyes	20/	20/	20/

Could visual acuity deficiency be corrected with glasses? Yes ☐ No ☐

Are glasses being fitted? Yes ☐ No ☐

Are there any progressive abnormalities? Yes ☐ No ☐

9. Please identify any driving restrictions you feel are necessary for this patient to safely operate a commercial motor vehicle: _____

_____

10. Please identify any driving restrictions currently on the applicant license that can be removed:

_____

I hereby acknowledge that I have examined the applicant to determine the physical and / or visual fitness for operating a commercial motor vehicle. It is my determination, based on my evaluation, the applicant should:

☐ **Be issued a commercial medical / vision waiver and be permitted to drive a commercial motor vehicle on an intrastate basis**

The medical / vision waiver shall be valid for the term indicated below, (but may not exceed 2 years.)

☐ **6 months** ☐ **1 year** ☐ **2 years** ☐ **Other:** _____

☐ **Be permitted to operate a commercial motor vehicle with NO medical / vision waiver. The driver meets or exceeds physical requirements as found in 49 C.F.R. 391.41**

☐ **Not be issued a commercial medical / vision waiver and should not be driving a commercial motor vehicle at this time**

_____ _____

Date of Examination Signature of Attending Physician

_____ _____

Physician's Office Phone Number Please Print Name Of Physician

_____

Office Address of Physician City State and Zip

I hereby authorize any physician, surgeon, medical practitioner or other person, and / or any clinic, hospital including the Veteran's Administration or government hospital to release any and all medical information acquired concerning the above specified medical condition or concerning any other medical condition that relates to or affects my ability to operate a motor vehicle safely.

_____ _____

Patient's Signature Date

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