



305 Galletti Way  
 Reno, Nevada 89512  
 Reno/Sparks/Carson City (775) 684-4DMV (4368)  
 Las Vegas Area (702) 486-4DMV (4368)  
 Rural Nevada or Outside Nevada (877) 368-7828  
 Fax: (775) 684-4829  
 Website: [www.dmvnv.com](http://www.dmvnv.com)

## Commercial Medical Waiver Application and Medical Evaluation

**This application packet is to be completed by the driver, their employer and a licensed physician prior to submitting to the Department of Motor Vehicles.**

**Applicant to complete this section:**

Daytime Telephone Number: \_\_\_\_\_

Driver 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? \_\_\_\_\_

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

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

**If Yes**, Which class of license did 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?

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 \_\_\_\_\_

**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: \_\_\_\_\_

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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: \_\_\_\_\_

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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** \_\_\_\_\_

# Medical Evaluation

## Waiver Restrictions:

- Nevada Medical Wavier 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.
- An applicant will be restricted from transporting passengers for compensation or hazardous materials if the applicant has suffered any fainting or dizzy spells, seizures or other similar disorders for 3 years preceding the date of the application.
- An applicant may be restricted from transporting passengers or hazardous materials if so prescribed by a licensed physician.

1. Identify and describe the visual or physical impairment of the applicant requiring a commercial medical waiver: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 Yes, 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

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 permitted to operate a commercial motor vehicle with NO medical waiver. The driver meets or exceeds physical requirements as found in 49 C.F.R. 391.41**
- Be issued a commercial medical waiver and be permitted to drive a commercial motor vehicle on an intrastate basis**

**The medical waiver shall be valid for the term indicated below, but may not exceed 2 years.**

**6 months**     **1 year**     **2 years**     **Other** \_\_\_\_\_

- Not be issued a commercial medical 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