PHYSICAL EXAMINATION CERTIFICATION FORM (JANUARY 22, 2014)

The most current version of this form is available at [www.cityofchicago.org/bacp](http://www.cityofchicago.org/bacp) and must be signed by an Illinois licensed physician. All fields marked with an asterisk (*) must be completed. Outdated, incomplete, edited (erased, crossed out, or whitened out text) forms will not be accepted.

*Print Applicant Name: ____________________________

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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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I, an applicant for a public chauffeur license, authorize the below listed physician and/or medical facility to release my medical records (medical, screening results, optical, etc.) to the City of Chicago upon request.

*Applicant Signature: ____________________________  *Date: ____________________________

The healthcare provider must confirm applicant identity and perform the following:

1. Complete physical exam
2. TB screening (Ask TB screening questions regarding symptoms, immunosuppression, travel, and contact with others with TB. If no risk factors identified, no need for additional testing. If risk factors are identified, perform a TST or IGRA, as indicated. The healthcare provider must assess for evidence of active TB if the TST or IGRA is positive. Reference for TB testing and diagnosis at [www.cdc.gov/tb/topic/testing/default.htm#who](http://www.cdc.gov/tb/topic/testing/default.htm#who).)
3. Vision screening (must demonstrate at least 20/40 in the best eye, with or without correction)
4. Auditory screening (must be able to first perceive a forced whispered voice in the better ear at not less than five feet with or without the use of a hearing aid or if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz and 2,000 Hz with or without a hearing aid. Refer to [http://www.fmcsa.dot.gov/rules-regulations/administration/fmcsr/fmcsrruletext.aspx?reg=391.43](http://www.fmcsa.dot.gov/rules-regulations/administration/fmcsr/fmcsrruletext.aspx?reg=391.43))

*DATE OF EXAMINATION: ____________________________  ►Select one of the below by (1) circling the statement number and (2) listing the applicant’s name on the applicable line.

1. I certify that ____________________________ IS capable of safely driving and operating a public passenger vehicle based upon my medical opinion and the results of the above listed examination and screenings.

2. I certify that ____________________________ IS NOT capable of safely driving and operating a public passenger vehicle based upon my medical opinion and the results of the above listed examination and screenings.

3. I referred ____________________________ for further evaluation. My certification is deferred pending the results of further evaluation.

*Printed Name of Illinois Licensed Physician: ____________________________  *Physician License Number: ____________________________

*Address: Street Unit/Suite Number City State ZIP Code

(______)  *Office Telephone Number

*E-Mail Address

*Signature of above listed Illinois Licensed Physician: ____________________________  *Date Signed