Safety Reference

Submission of Renewable DQ File Documents

DQ file documents require clear, complete, and legible images for purposes of auditing the document for acceptance in a drivers DQ file. Submission of renewable DQ file documents to DQFileDocuments@pods.com should follow the following criteria, or otherwise be rejected.

*Note: attachments **cannot** include multiple drivers (only 1 driver per 1 attachment).*

Drivers Licenses

- Copy of **both sides (front/back)** must be included in the same file attachment.
- All 4 corners should be visible, and not cut-off.
- Information should be legible and clearly identify:
  - Driver's name
  - License Number
  - License Class
  - Expiration Date
  - Issue Date
- Documents will be rejected for the following reasons:
  - Blurred image(s) causing illegibility
  - Glares over critical information / photo
  - Image cut-off
  - Partial document (missing a side of the license)

Medical Card

- The only acceptable medical examiner's certification document is **Form MCSA-5876**
  - Referenced in the upper left corner of document.
- Entirety of the form should be legible with clearly identifiable completion of *all* required fields by the examining physician and the driver.
  - *(See the sample med card provided in this reference sheet, highlighting the fields required for completion)*
- All 4 corners of the original copy should be visible, and not cut-off.
- Documents will be rejected for the following reasons:
  - Document version is incorrect / outdated
  - Blurred image(s) causing illegibility
  - Glares over critical information
  - Image cut-off

Safety Reference

Example Only.

Highlighted sections must be completed by medical examiner & driver. Any completions after-the-fact are considered fraudulent, unless overseen by issuing physician.

Form MCSA-5876 OMB No.: 2126-0006 Expiration Date: 03/31/2025

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately one minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examiner's Certificate
(for Commercial Driver Medical Certification)

I certify that I have examined **Last Name:** _____ **First Name:** _____ in accordance with *(please check only one)*:

- ◯ 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 *(check all that apply)* **OR**
- ◯ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when *(check all that apply)*:

☐ Wearing corrective lenses ☐ Accompanied by a _____ waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Grandfathered from State requirements *(State)*

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date

Medical Examiner's Signature

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name *(please print or type)*

◯ MD ◯ Physician Assistant ◯ Advanced Practice Nurse
◯ DO ◯ Chiropractor ◯ Other Practitioner *(specify)* _____

Medical Examiner's State License, Certificate, or Registration Number

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____

CLP/CDL Applicant/Holder
◯ Yes ◯ No

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

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