APPLICATION FOR WAIVER OF PHYSICAL DEFICIENCY

RSA 266:72-a, III, authorizes the commissioner to waive specific requirements or standards of the medical examination for drivers of all vehicles subject to the motor carrier safety rules who operate exclusively in intrastate commerce and do not carry hazardous materials, if it would not jeopardize the public safety. The specific requirements and standards for the medical examinations are contained in Title 49 of the Code of Federal Regulations part 391.43

Additional copies of this application may be obtained by written request to:

NH Department of Safety
Division of Motor Vehicles – Director’s Office
23 Hazen Drive
Concord, New Hampshire 03305
or by calling: (603) 227-4050

TECHNICAL ASSISTANCE

Please read the entire application thoroughly before filling it out. Technical assistance is available if you need help completing this application. For technical assistance, please contact the Division of Motor Vehicles (603) 227-4050 at the address or telephone number listed above and a Trooper will be assigned to your case.

DUTIES

The waiver of Physical Deficiency shall authorize the driver-applicant to operate only the type of motor vehicle(s) defined in the waiver when the driver-applicant is in compliance with all the conditions and limitations of the waiver or legible copy in his/her possession whenever on duty.

TERMS AND LIMITATIONS

A Waiver of Physical Deficiency shall be valid for a period not to exceed two (2) years from date issued and the renewal process may be initiated sixty (60) days prior to the expiration date.

FALSE INFORMATION

Falsifying information in this application by either the driver-applicant or the motor carrier shall be just cause to deny the granting of a granting a waiver and shall also be just cause to revoke a waiver (RSA 641:3).

DSMV 558 (Rev 04/19)
INSTRUCTIONS

THIS APPLICATION SHALL BE ACCOMPANIED BY THE FOLLOWING:

A copy of the results of the medical examination performed (pursuant to 49CFR 391.43).

A copy of the medical certificate completed (pursuant to 49 CFR 391.43 (e)).

A medical evaluation summary completed by a licensed physician. The driver-applicant shall provide the physician with a description of the job tasks he/she will be required to perform.

The summary shall include an assessment of the driver’s functional capabilities as they relate to his/her ability to perform normal tasks associated with operating a commercial motor vehicle; or

An explanation as to whether the impairment interferes with the driver’s ability to perform normal tasks associated with operating a commercial motor vehicle. The summary shall also contain an assessment of whether the condition will likely remain medically stable over the driver-applicant’s lifetime.

A description of the driver-applicant’s prosthetic or orthotic device, if any and a statement regarding whether the driver-applicant is capable of demonstrating precision prehension

The driver-applicant shall be responsible for submitting a completed copy of the employment application from the last commercial driving position he/she held pursuant to 49CFR 391.21). If not previously employed as a commercial driver, so state.

A copy of the driver-applicant’s waiver of physical defects issued by the individual State(s) and/or the Federal Highway Administration, where applicable.

A copy of the driver-applicant’s certified State Motor Vehicle record for the past three (3) years from each state in which a driver license or permit has been obtained, any at fault accident report records on file for the past ten (10) years (Saf-C909-09(a)3).

AFTER COMPLETING THE APPLICATION:

Recheck the application for completeness
Be sure to enclose or attach all applicable supporting documentation to:

New Hampshire Department of Safety
Division of Motor Vehicles
23 Hazen Drive
Concord NH 03305
DRIVER-APPLICANT - GENERAL INFORMATION

CHECK ONE: New Applicant ☐ Renewal ☐

Last Name: ____________________________ First Name: ____________________________ MI: __
Date of Birth: __/__/____ Home Phone: ( ) ____-_____ Work Phone: ( ) ____-_____
Street Address ________________________________________________________________
City/Town: __________________ State: _______ Zip Code: __________
Type of Driver License (example: operator, or CDL- A,B,C): _______ State_______

MOTOR CARRIER CO-APPLICANT - GENERAL INFORMATION

Name of Motor Carrier: ____________________________ Contact Person: _________________
Phone: ( ) ____-______ Street Address: __________________________________________
City: __________________ State: ______ Zip Code :) ______

REQUIRED INFORMATION

Description of driver-applicant’s physical deficiency for which the waiver is requested: __________
Date of deficiency: ____/____/_____
Description of the type of operation the driver will be employed to perform __________________________

Average period of time the driver will be driving each day while on duty: ______________________
Type of commodities or cargo to be transported: ________________________________
Type of driver operation: (sleeper – team, relay, owner/operator, etc) - _______________
Number of years experience operating commercial motor vehicle and total years of experience
driving all types of motor vehicles: _______________________________/_____________________
Description of the vehicle (s) driver-applicant intends to drive: __________________________
Truck or truck-tractor make, model, and year (if known): ______________________________
Transmission type (auto or manual – if manual; designate number of forward speeds): _______

Auxiliary transmission (if any) and number of forward speeds: __________________________
Rear Axle (designate single speed, 2-speed, or 3-speed): ______________________________
Designation of geographic area of the state in which the driver-applicant intends to travel:
________________________________________________________________________

Steering – manual or power assisted:____________________________________________

Description of type of trailer(s) (example: van, flatbed, cargo tank, lowboy, or pole):________

Number of semi-trailers or full trailers to be towed at one time:_________________________

Description of any vehicle modification(s) made for the driver-applicant (attach photograph(s) where applicable): ________________________________

Seating capacity of passenger carrying vehicles:_____________________________________

The co-applicant motor carrier must certify that the driver-applicant is otherwise qualified under the regulations of 49 CFR 391, Qualifications of Drivers:

THIS IS A NEW HAMPSHIRE ONLY MEDICAL WAIVER

___________________________________________ __________________ / / __________
Driver –applicant’s Signature Date

IF APPLICABLE:
______________________________________________
PRINT NAME

MOTOR CARRIER OFFICIAL’S SIGNATURE ________________________________
(Corporate Officer, partner or proprietor)

/ / __________ Date

GRANTING OR DENIAL OF WAIVER

The application shall be reviewed by the Director of the Division of Motor Vehicles and submitted to the Assistant Commissioner of Safety with a recommendation to grant or deny a waiver. Final determination shall be made by the Commissioner and the applicant shall be notified in writing by the Commissioner. Approvals shall include terms, conditions, limitations, and additional information deemed pertinent by the Commissioner.

If an applicant is denied, the applicant may petition the bureau of Hearings and request a REVIEW OF THE APPLICATION AND SUBSEQUENT DENIAL. Such a request must be submitted in writing with the petitioner’s name, address, and date of birth to:

NEW HAMPSHIRE DEPARTMENT OF SAFETY
BUREAU OF HEARINGS
33 HAZEN DRIVE
CONCORD, NEW HAMPSHIRE  03305
APPLICATION FOR EMPLOYMENT

COMPANY: ___________________________ Street Address: ___________________________
City, State and Zip Code: ____________________________________________________________

Name: ____________________________________________________________ How Long? _____
First, middle, (maiden if any) Last

Address: ____________________________________________________________ How Long? _____
Street City State & Zip Code

Date of Birth: ____/____/______ Social Security #: ____-____-_____

FOR THE PAST THREE YEARS: (If applicable)

Address: ____________________________________________________________ How Long? _____
Street City State & Zip Code

Address: ____________________________________________________________ How Long? _____
Street City State & Zip Code

(Attach more sheets if more space is needed)

EXPERIENCE AND QUALIFICATIONS - DRIVER

Drivers Licenses: License #: Type: Exp date: 

State
Drivers Licenses: License #: Type: Exp date: 

State
Drivers Licenses: License #: Type: Exp date: 

State

Driving Experience:
Class of Equipment: Type of Equipment (van, Tank, Flat, etc) Dates from To Approx # Miles
Straight Truck ___________________ ___________________ ___________________ ____________
Tractor and Semi Trailer __________ __________ __________ __________ __________
Tractor-Two Trailers __________ __________ __________ __________ __________
Other

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED):

DATES: NATURE OF ACCIDENT (Head-on, Rear-end, Upset, Etc) FATALITIES INJURIES

Last accident: ___________________ / ___________________ / ___________________

Next Previous: ___________________ / ___________________ / ___________________
Next Previous: ___________________ / ___________________ / ___________________
### TRAFFIC CONVICTIONS and FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS):

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DATE</th>
<th>CHARGE</th>
<th>PENALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ATTACH SHEET IF MORE SPACE NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle?  Yes ______  No ______

B. Has any license, permit or privilege ever been suspended or revoked?  Yes ______  NO______

If the answer to either A or B is yes Attach statement giving details :

### EMPLOYMENT RECORD (Attach Sheet if more Space is Needed)

Note: DOT Requires that Employment for at Least 3 Years and / or Commercial Driving Experience for the past 10 Years be shown

**LAST EMPLOYER:**

NAME: ____________________________

ADDRESS: ________________________________________________________________________________________________

POSITION HELD: ___________________ FROM: __________________ TO: __________________ SALARY: _____________

REASON FOR LEAVING: ______________________________________________________________________________________

**SECOND LAST EMPLOYER:**

NAME: ____________________________

ADDRESS: ________________________________________________________________________________________________

POSITION HELD: ___________________ FROM: __________________ TO: __________________ SALARY: _____________

REASON FOR LEAVING: ______________________________________________________________________________________

**THIRD LAST EMPLOYER:**

NAME: ____________________________

ADDRESS: ________________________________________________________________________________________________

POSITION HELD: ___________________ FROM: __________________ TO: __________________ SALARY: _____________

REASON FOR LEAVING: ______________________________________________________________________________________

---

**TO BE READ AND SIGNED BY APPLICANT**

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

_________________________________________  ____________________________
DATE                                                                 APPICANT’S SIGNATURE

---

**NOTE:** A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.
The medical evaluation summary must be completed by a licensed physician. The driver-applicant shall provide the physician with a description of the job task he will be required to perform.

TO THE PHYSICIAN:

The summary shall include an assessment of the driver’s functional capabilities as they relate to his/her ability to perform normal tasks associated with operating a commercial motor vehicle; or

An explanation as to how and why the impairment interfered with the driver’s ability to perform normal tasks associated with operating a commercial motor vehicle. The summary shall also contain an assessment of whether the condition will likely remain medically stable over the driver-applicant’s lifetime.

Please print or type.
Applicants Name: ___________________________ DOB: / / 

Please use the space below for your medical evaluation summary

__________________________________________________________________________

Signature of Physician Date

Name of Physician: ___________________________
Name of Practice: ___________________________
Address: _________________________________
Telephone #: _______________________________