Wellstar Internal Medicine Associates
355 Tower Road Suite 300
Marietta GA 30060-9408
Dept: 770-427-2457
Dept Fax: 770-427-2706

November 12, 2021

Patient: **Rigoberto Acevedo**
Date of Birth: **10/11/1962**
Date of Visit: **11/12/2021**

To Whom It May Concern:

It is my medical opinion that Rigoberto Acevedo's chronic issues have been well controlled and he is physically capable for performing his current job. His cardiac stress test is negative. DOT physical exam is pending.

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If you have any questions or concerns, please don't hesitate to call.

Sincerely,

Jie Liu, MD

Form MCSA-5876

OMB No. 2126-0006 Expiration Date: 11/30/2021

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 1 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:** ACEVEDO **First Name:** Rigoberto 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)*:

- [x] Wearing corrective lenses
- [ ] Wearing hearing aid
- [ ] Accompanied by a _____ waiver/exemption
- [ ] Accompanied by a Skill Performance Evaluation (SPE) Certificate
- [ ] Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
- [ ] Qualified by operation of 49 CFR 391.64 *(Federal)*
- [ ] 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
11-15-2022

Medical Examiner's Signature

Medical Examiner's Telephone Number
(770) 590-4190

Date Certificate Signed
11/15/2021

Medical Examiner's Name *(please print or type)*
JUSTIN R. MURPHY, PA-C

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

Medical Examiner's State License, Certificate, or Registration Number
9445

Issuing State
Georgia

National Registry Number
7205323892

Driver's Signature

Driver's License Number
054131676

Issuing State/Province
GEORGIA

Driver's Address

Street Address: 4725 N. Cobb Pkwy NW LOT 73 City: Acworth State/Province: GA Zip Code: 30101

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.

Wellstar
HEALTH SYSTEM

Payment Receipt

Receipt Number:	13142074	Receipt Date:	11/15/2021
Guarantor ID:	74116	Guarantor Name:	Rigoberto Acevedo
Payment Total:	$95.00	Payment Location:	Wellstar Urgent Care at Church Street
Patient Name:	Rigoberto Acevedo	CC Auth:	125435

Account #	Appt/Admit Date	Type	Source	Reference	Payment
Future	11/15/2021	Other	Credit Card	125435 MasterCard x6107	$95.00
			Total Amount:		**$95.00**

Signature: _____

The vision of Wellstar Health System is to deliver world-class healthcare through our hospitals, physicians and services. Our not-for-profit health system includes Wellstar Kennestone Regional Medical Center, Wellstar Cobb, Douglas, Paulding, Windy Hill, North Fulton, Sylvan Grove and Spalding Regional hospitals; Wellstar Atlanta Medical Center, Wellstar Atlanta Medical Center South, Wellstar West Georgia Medical Center, Wellstar Medical Group, Health Parks, Urgent Care Centers, Health Place, Homecare, Hospice, Atherton Place, Paulding Nursing Center and Wellstar Foundation.

Form MCSA-5875 OMB No. 2126-0006 Expiration Date: 11/30/2021

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

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #
_____
(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: ACEVEDO First Name: Rigoberto Middle Initial: ____ Date of Birth: 10-11-62 Age: 59

Street Address: 4725 N. Cobb Pkwy NW Lot 73 City: Acworth State/Province: GA Zip Code: 30101

Driver's License Number: 054 131 676 Issuing State/Province: GA Phone: 470 757 Gender: ⊗ M ○ F

E-mail *(optional)*: RR.Acevedo@Hotmail.com CLP/CDL Applicant/Holder*: ⊗ Yes ○ No

Driver ID Verified By**: FRONT OFFICE ASSOCIATE

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ⊗ Yes ○ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ⊗ **Yes** ○ **No** ○ **Not Sure**

Triple Bypass

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? ⊗ **Yes** ○ **No** ○ **Not Sure**
If "yes," please describe below.

Yes (List of medications attach to this form.)
valtrex, potassium, multivitamin, metoprolol, metformin, lisinopril, glipizide, furosemide, tamsulosin, aspirin

(Attach additional sheets if necessary)

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Last Name: Acevedo First Name: Gigoberto DOB: 10-11-62 Exam Date: 11-15-21

DRIVER HEALTH HISTORY *(continued)*

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses *(e.g., concussion)*	○	⊗	○
2. Seizures, epilepsy	○	⊗	○
3. Eye problems *(except glasses or contacts)*	○	⊗	○
4. Ear and/or hearing problems	○	⊗	○
5. Heart disease, heart attack, bypass, or other heart problems	⊗	○	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	⊗	○
7. High blood pressure	⊗	○	○
8. High cholesterol	⊗	○	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	⊗	○
10. Lung disease *(e.g., asthma)*	○	⊗	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	⊗	○
12. Stomach, liver, or digestive problems	○	⊗	○
13. Diabetes or blood sugar problems	⊗	○	○
Insulin used	○	○	○
14. Anxiety, depression, nervousness, other mental health problems	○	⊗	○
15. Fainting or passing out	○	⊗	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	⊗	○
17. Unexplained weight loss	○	⊗	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	⊗	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	⊗	○
20. Neck or back problems	○	⊗	○
21. Bone, muscle, joint, or nerve problems	○	⊗	○
22. Blood clots or bleeding problems	○	⊗	○
23. Cancer	○	⊗	○
24. Chronic (long-term) infection or other chronic diseases	○	⊗	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	⊗	○
26. Have you ever had a sleep test *(e.g., sleep apnea)*?	⊗	○	○
27. Have you ever spent a night in the hospital?	⊗	○	○
28. Have you ever had a broken bone?	○	⊗	○
29. Have you ever used or do you now use tobacco?	⊗	○	○
30. Do you currently drink alcohol?	○	⊗	○
31. Have you used an illegal substance within the past two years?	○	⊗	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	⊗	○

Other health condition(s) not described above: ○ Yes ⊗ No ○ Not Sure

NONE

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ⊗ Yes ○ No ○ Not Sure

triple By Pass (2016) and Diabetes Problem are control. by Medications (Doctor letter are attach to this form.) A1C 7.4 (11/5/21) SLEEP STUDY 2017 NEGATIVE FOR OSA.

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: 11-15-21

SECTION 2. Examination Report *(to be filled out by the medical examiner)*

DRIVER HEALTH HISTORY REVIEW

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

I HAVE REVIEWED THE HISTORY DOCUMENTED.

(Attach additional sheets if necessary)

Last Name: Acevedo First Name: Rigoberto DOB: 10-11-62 Exam Date: 11-15-21

TESTING

Pulse rate: 77 Pulse rhythm regular: ✓ Yes ○ No Height: 5 feet 9 inches Weight: 298 pounds

Blood Pressure	Systolic	Diastolic
Sitting	137	86
Second reading (optional)	—	—

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.030	NEG	NEG	NEG

Other testing if indicated

—

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/___	20/25	Right Eye: 70 degrees
Left Eye:	20/___	20/25	Left Eye: 70 degrees
Both Eyes:	20/___	20/25	

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors	✓	○
Monocular vision	○	✓
Referred to ophthalmologist or optometrist?	○	✓
Received documentation from ophthalmologist or optometrist?	○	○

Hearing

*Standard: Must first perceive whispered voice at not less than 5 feet **OR** average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).*

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☑ Neither

Whisper Test Results

	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	8 ft	8 ft

OR

Audiometric Test Results

	Right Ear			Left Ear		
	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
	—			—		

Average (right): — Average (left): —

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	✓	○	8. Abdomen	✓	○
2. Skin	✓	○	9. Genito-urinary system including hernias	✓	○
3. Eyes	✓	○	10. Back/Spine	✓	○
4. Ears	✓	○	11. Extremities/joints	✓	○
5. Mouth/throat	✓	○	12. Neurological system including reflexes	✓	○
6. Cardiovascular	✓	○	13. Gait	✓	○
7. Lungs/chest	✓	○	14. Vascular system	✓	○

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

N/A

(Attach additional sheets if necessary)

Form MCSA-5875 OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Acevedo First Name: Rigoberto DOB: 10-11-62 Exam Date: 11-15-21

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- ○ Does not meet standards *(specify reason)*: _____
- ○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ◉ Meets standards, but periodic monitoring required *(specify reason)*: _____
  - Driver qualified for: ○ 3 months ○ 6 months ◉ 1 year ○ other *(specify)*: _____
- ☑ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*
- ☐ Driving within an exempt intracity zone *(see 49 CFR 391.62) (Federal)*
- ☐ Determination pending *(specify reason)*: _____
  - ☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____
  - ☐ Medical Examination Report amended *(specify reason)*: _____
    - *(if amended)* Medical Examiner's Signature: _____ Date: _____
- ☐ Incomplete examination *(specify reason)*: _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: _____

Medical Examiner's Name *(please print or type)*: JUSTIN R. MURPHY, PA-C

Medical Examiner's Address: 818 CHURCH ST NW, SUITE 100 City: MARIETTA State: GA Zip Code: 30060

Medical Examiner's Telephone Number: (770) 590-4190 Date Certificate Signed: 11/15/2021

Medical Examiner's State License, Certificate, or Registration Number: 9445 Issuing State: GA

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☒ (IN) Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: 7205323892

Medical Examiner's Certificate Expiration Date: 11/15/2022

Cambios a su lista de medicamentos

ⓘ Actualizado noviembre 15, 2021 11:08 AM.
Si tiene alguna pregunta, contacte con su personal médico.

SIGA tomando estos medicamentos

aspirin 81 MG tablet, delayed release	Take 1 tablet (81 mg total) by mouth daily
atorvastatin 80 MG tablet También conocido como: LIPITOR	Take 80 mg by mouth nightly
ezetimibe 10 mg tablet También conocido como: ZETIA	Take 1 tablet (10 mg total) by mouth daily
FreeStyle Libre 14 Day Reader Misc Medicamento genérico: flash glucose scanning reader	1 application by Miscellaneous route 4 (four) times a day
FreeStyle Libre 14 Day Sensor Kit Medicamento genérico: flash glucose sensor	1 application by Miscellaneous route 4 (four) times a day
furosemide 20 MG tablet También conocido como: LASIX	Take 1 tablet (20 mg total) by mouth daily
glipiZIDE 5 MG tablet También conocido como: GLUCOTROL	TAKE 1 TABLET BY MOUTH TWICE DAILY BEFORE MEALS
lisinopriL 20 MG tablet También conocido como: ZESTRIL	Take 1 tablet (20 mg total) by mouth daily
metFORMIN 1000 MG tablet También conocido como: GLUCOPHAGE	Take 1 tablet (1,000 mg total) by mouth 2 (two) times a day with meals
metoprolol succinate ER 25 MG tablet, extended release 24 hr También conocido como: TOPROL-XL	Take 1 tablet (25 mg total) by mouth daily
MULTI-BETIC ORAL	Take 1 tablet by mouth daily
potassium chloride SA 10 MEQ tablet, extended release También conocido como: Klor-Con M10	Take 1 tablet (10 mEq total) by mouth daily
valACYclovir 500 MG tablet También conocido como: VALTREX	Take 1 tablet (500 mg total) by mouth daily