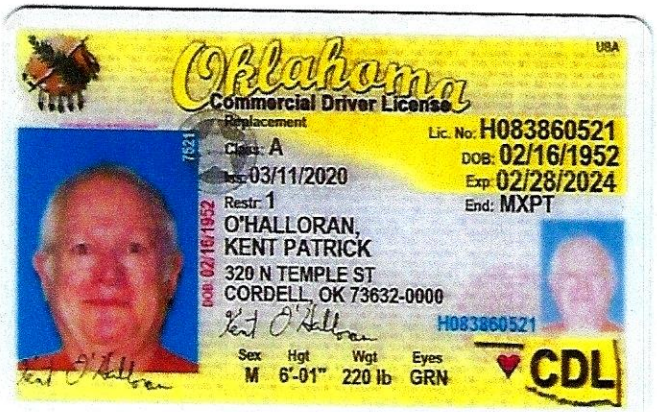
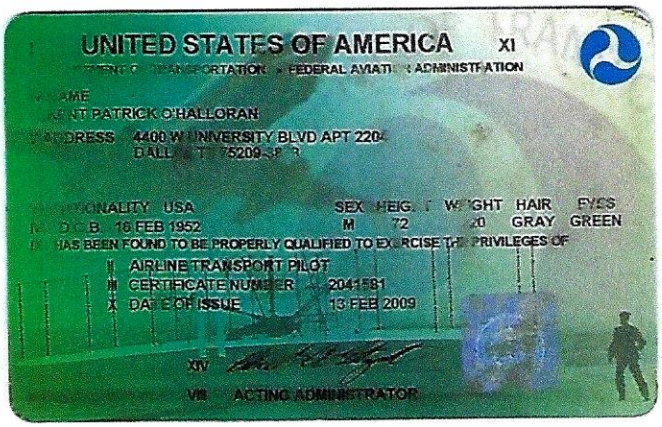
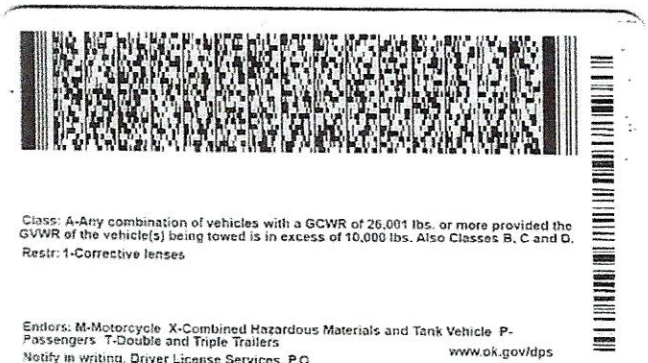
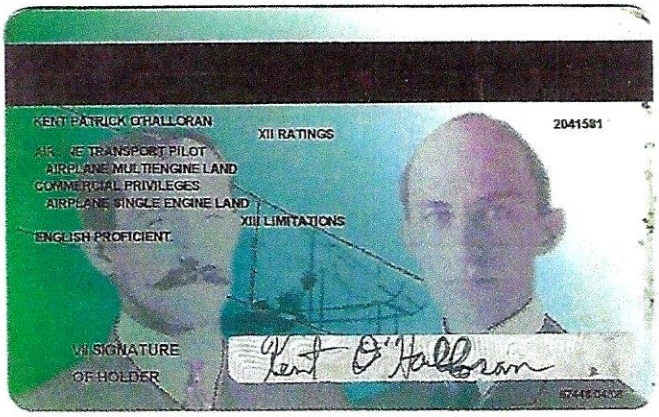








Form MCSA-5876 OMB No. 2126-0006 Expiration Date: 11/30/2021

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, DC 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 O'Halloran First Name Kent P. 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 391.41-391.42) 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 ☐ 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: 12-04-2022

Medical Examiner's Signature: Michael Krieger MD

Medical Examiner's Telephone Number: 580-726-5627

Date Certificate Signed: 12-04-2020

Medical Examiner's Name (please print or type): Michael Krieger M.D.

☒ MD ○ Physician Assistant ○ Advanced Practice Nurse
○ DO ○ Chiropractor ○ Other Practitioner (specify)

Medical Examiner's State License, Certificate, or Registration Number: 13303

Issuing State: OK

National Registry Number: 7094727245

Driver's Signature: Kent O'Halloran

Driver's License Number: H083860521

Issuing State/Province: OK

Driver's Address
Street Address: 320 N. Temple City: Cordell State/Province: OK Zip Code: 73632

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.

UNITED STATES OF AMERICA
Department of Transportation
Federal Aviation Administration

MEDICAL CERTIFICATE FIRST CLASS

This certifies that *(Full name and address):*

KENT Patrick O'HALLORAN
PO Box 176--320 N Temple St
Cordell OK 736320176 USA

Date of Birth	Height	Weight	Hair	Eyes	Sex
02/16/1952	73	234	GRAY	GREEN	M

has met the medical standards prescribed in part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations: ~~Must wear corrective lenses.~~

Examiner
Date of Examination: 02/06/2020
Examiner's Designation No.: 00001931
Signature
Typed Name: CHARLES E WOMACK , MD

AIRMAN'S SIGNATURE Kent O'Halloran

Applicant ID: 1996502725 Control No.: 200009003314

FAA Form 8500-9 (3-12) Supersedes Previous Edition NSN: 0052-00-670-7002

Keep this stub with your personal records. The other side contains important information.

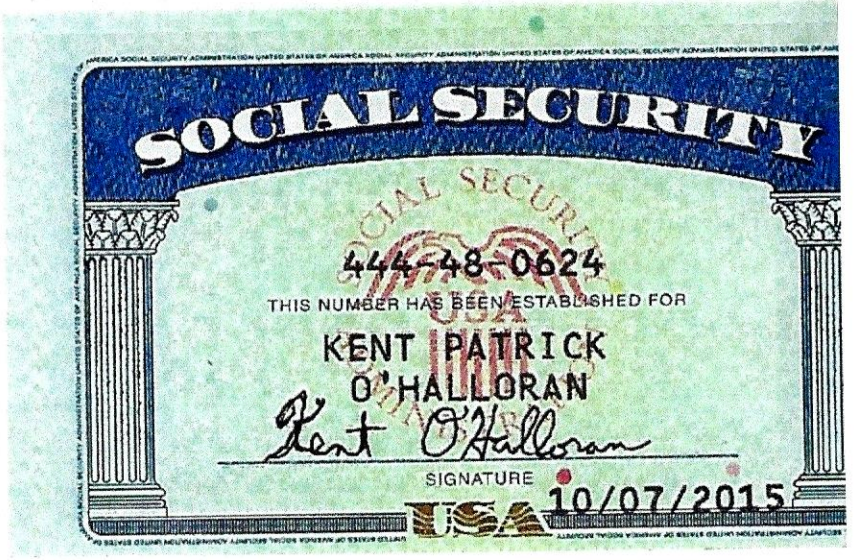
Please note: The date we issued this card is shown below the signature line.

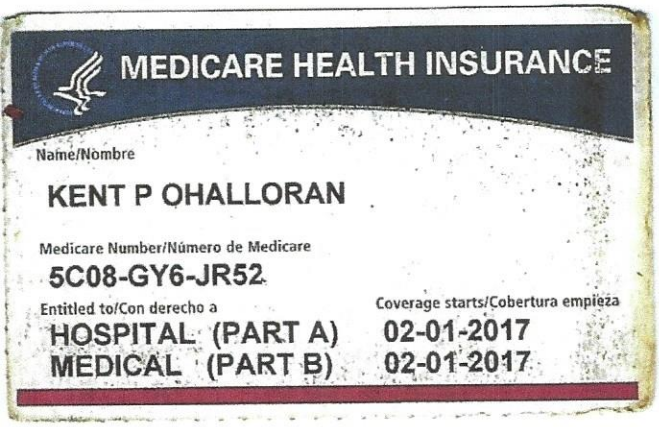
KENT PATRICK O'HALLORAN
PO BOX 176
320 N TEMPLE STREET
CORDELL OK 73632-0176

YOUR SOCIAL SECURITY CARD

ADULTS: Sign this card in ink immediately.
CHILDREN: Do not sign until age 18 or your first job, whichever is earlier.

Keep your card in a safe place to prevent loss or theft.
DO NOT CARRY THIS CARD WITH YOU.
Do not laminate.





MEDICARE HEALTH INSURANCE

Name/Nombre

KENT P OHALLORAN

Medicare Number/Número de Medicare

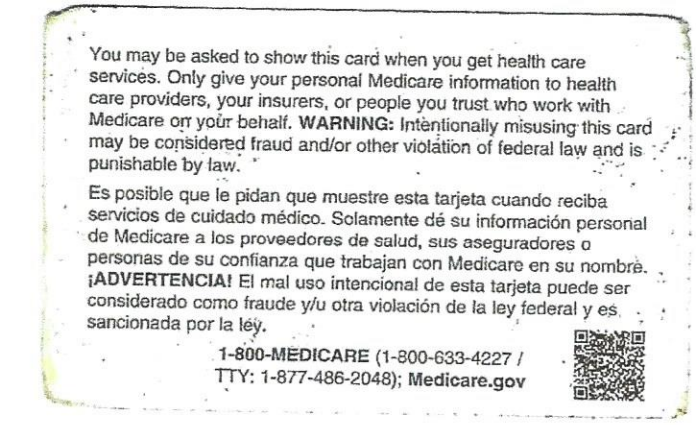
5C08-GY6-JR52

Entitled to/Con derecho a	Coverage starts/Cobertura empieza
HOSPITAL (PART A)	02-01-2017
MEDICAL (PART B)	02-01-2017

You may be asked to show this card when you get health care services. Only give your personal Medicare information to health care providers, your insurers, or people you trust who work with Medicare on your behalf. **WARNING:** Intentionally misusing this card may be considered fraud and/or other violation of federal law and is punishable by law.

Es posible que le pidan que muestre esta tarjeta cuando reciba servicios de cuidado médico. Solamente dé su información personal de Medicare a los proveedores de salud, sus aseguradores o personas de su confianza que trabajan con Medicare en su nombre. **¡ADVERTENCIA!** El mal uso intencional de esta tarjeta puede ser considerado como fraude y/u otra violación de la ley federal y es sancionada por la ley.

1-800-MEDICARE (1-800-633-4227 / TTY: 1-877-486-2048); **Medicare.gov**



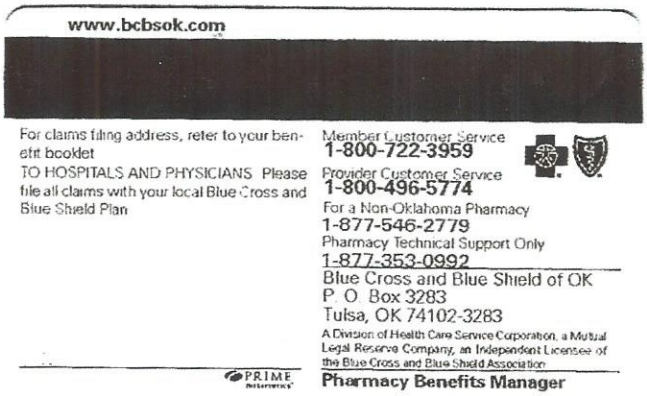
BlueCross BlueShield of Oklahoma

Member Name
KENT P O'HALLORAN
Member ID
YUA935627615

Group No.	0OK207
BIN	011552
Rx PCN	1215
Plan Code	BC 340 BS 840
Effective Date	02/01/17

Plan
HIGH DEDUCTIBLE PLAN F

Rx



www.bcbsok.com

[redacted]

For claims filing address, refer to your benefit booklet
TO HOSPITALS AND PHYSICIANS Please file all claims with your local Blue Cross and Blue Shield Plan

Member Customer Service
1-800-722-3959
Provider Customer Service
1-800-496-5774
For a Non-Oklahoma Pharmacy
1-877-546-2779
Pharmacy Technical Support Only
1-877-353-0992
Blue Cross and Blue Shield of OK
P. O. Box 3283
Tulsa, OK 74102-3283
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

PRIME THERAPEUTICS
Pharmacy Benefits Manager

COVID-19 Vaccination Record Card

Please keep this record card, which includes medical information about the vaccines you have received.

Por favor, guarde esta tarjeta de registro, que incluye información médica sobre las vacunas que ha recibido.

O'HALLORAN KENT P.
Last Name First Name MI

2-16-1952
Date of birth

Patient number *(medical record or IIS record number)*

Vaccine	Product Name/Manufacturer Lot Number	Date	Healthcare Professional or Clinic Site
1st Dose COVID-19	Moderna 011L20A	1-12-21 mm dd yy	WASHITA COUNTY FAIRGROUNDS WOMEN'S BLDG. CORDELL, OK
2nd Dose COVID-19	Moderna Lot# 011M20A 07/16/2021	2-9-21 mm dd yy	KCHD
Other		__/__/__ mm dd yy	KIOWA COUNTY HEALTH DEPT HOBART, OK.
Other		__/__/__ mm dd yy	

Reminder! Return for a second dose!
¡Recordatorio! ¡Regrese para la segunda dosis!

Vaccine	Date / Fecha
COVID-19 vaccine Vacuna contra el COVID-19	2/9/21 mm dd yy
Other Otra	__/__/__ mm dd yy

Bring this vaccination record to every vaccination or medical visit. Check with your health care provider to make sure you are not missing any doses of routinely recommended vaccines.

For more information about COVID-19 and COVID-19 vaccine, visit **cdc.gov/coronavirus/2019-ncov/index.html**.

You can report possible adverse reactions following COVID-19 vaccination to the Vaccine Adverse Event Reporting System (VAERS) at **vaers.hhs.gov**.

Lleve este registro de vacunación a cada cita médica o de vacunación. Consulte con su proveedor de atención médica para asegurarse de que no le falte ninguna dosis de las vacunas recomendadas.

Para obtener más información sobre el COVID-19 y la vacuna contra el COVID-19, visite **espanol.cdc.gov/coronavirus/2019-ncov/index.html**.

Puede notificar las posibles reacciones adversas después de la vacunación contra el COVID-19 al Sistema de Notificación de Reacciones Adversas a las Vacunas (VAERS) en **vaers.hhs.gov**.

09/03/20 MLS-319813_r

Subject: **Fwd: COVID Vaccine Notification - Booking Confirmation**
Date: 2/4/2021 6:57:22 AM Central Standard Time
From: em.washitaco@gmail.com
To: KPOH@aol.com

You will need to print off this paper are pull it up by email on your phone so they can scan the QR code. Thanks let me know when you receive this email please. thanks

---------- Forwarded message ---------
From: **OSDH Vaccine Scheduler5** <Noreply-vras5@health.ok.gov>
Date: Wed, Feb 3, 2021 at 10:26 PM
Subject: COVID Vaccine Notification - Booking Confirmation
To: Emergency Management Washita County <em.washitaco@gmail.com>

Hello Kent,

You have been approved to receive a COVID-19 Vaccine. "No touch" interactions will be implemented at all vaccine centers. Please bring your photo ID and the below confirmation code and/or QR code with you (on your phone or printed) and report to the vaccine center.

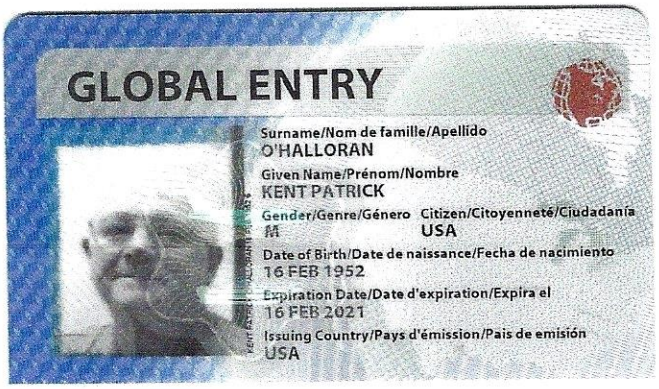
Scheduling Confirmation:

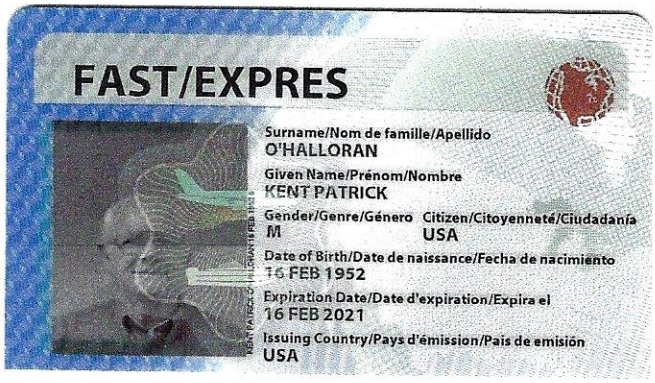
Name: Kent P. O'Halloran
Email: em.washitaco@gmail.com
Appointment ID: 157005-R1Y3V
Vaccine Location: SECOND DOSE ONLY - First Baptist Church
115 S Jefferson St
Hobart, Oklahoma 73651
Start Time: 2/8/2021 9:15 AM CST
End Time: 2/8/2021 9:30 AM CST

You can change your booking by clicking on this link
You can cancel your booking by clicking on this link

--
Washita County Emergency Management
Safety Coordinator & Flood Plain Administrator
P.O. Box 380 - 111 E. Main (1st Floor Court House)
Cordell, OK. 73632
580-832-4114 office 580-832-3526 fax
em.washitaco@gmail.com

IPUSAC215752567<<13<39<B02<699
5202164M2911113USA<<3449436923
OHALLORAN<<KENT<P<<<<<<<<<<<<<


GLOBAL ENTRY
Surname/Nom de famille/Apellido
O'HALLORAN
Given Name/Prénom/Nombre
KENT PATRICK
Gender/Genre/Género
M
Citizen/Citoyenneté/Ciudadanía
USA
Date of Birth/Date de naissance/Fecha de nacimiento
16 FEB 1952
Expiration Date/Date d'expiration/Expira el
16 FEB 2021
Issuing Country/Pays d'émission/Pais de emisión
USA


FAST/EXPRES
Surname/Nom de famille/Apellido
O'HALLORAN
Given Name/Prénom/Nombre
KENT PATRICK
Gender/Genre/Género
M
Citizen/Citoyenneté/Ciudadanía
USA
Date of Birth/Date de naissance/Fecha de nacimiento
16 FEB 1952
Expiration Date/Date d'expiration/Expira el
16 FEB 2021
Issuing Country/Pays d'émission/Pais de emisión
USA


Date of Issue/Date de délivrance/
Fecha de expedición
02 JUN 2015
B22655413
C01
6
PASSID/Numéro d'identification
985678715 SC771
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OHALLORAN<<KENT<<<<<<<<<<<<<<


Date of Issue/Date de délivrance/
Fecha de expedición
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C01
6
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