

JOHN P. BOYLE, JR. Director
Division of Public Safety

Ohio

COMMERCIAL LICENSE

HEINRICH
NELS A
2333 WOODSTOCK AVE
FAIRVIEW PARK OH 44126

1. LICENSE NO. 2. BIRTHDATE 3. EXPIRATION DATE
R0872846 04-14-1957 04-14-2022

4. CLASS 5. EXPIRES 6. ENDORS
A 04-14-2022 NT

10 Sex: M 11 Ht: 5-08 12 Wt: 180
13 Eyes: BRO 14 Hair: BRO

CLASS: A Combination > 26,000 Lbs > 10,000
ENDORSEMENTS: H - Tank, T - Chaff/Traffic
RESTRICTIONS: N - Corrective Lenses

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 Office, Federal Motor Carrier Safety Administration, MC-HSA, 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 Heinrich First Name Niels 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
☐ Wearing hearing aid ☐ 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

06/10/2022

Medical Examiner's Signature

Medical Examiner's Name (please print or type)

Richardson, Rhia

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

34,009,384

Medical Examiner's Telephone Number

(216) 749-2730

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

Date Certificate Signed

06/10/2020

National Registry Number

1060493496

Driver's Signature

Driver's Address

Street Address: 20936 Woodstock

Driver's License Number

RU872846

Issuing State/Province

OH

City: FAIRVIEW PARK

State/Province: OH

Zip Code: 44126

☒ Yes ☐ No

CLP/CDL Applicant/Holder

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.

Medical Examiner's Certificate

Examinee Information
 Last Name: First Name: DOB: Sex:
 Address: City: State: Zip:
 Phone: Email:

Examination Information
☐ On-site Medical Examiner Safety Inspection (MSI) 10/1/2018 and with knowledge of the above dates (that only person is qualified, and if a first-time person is qualified, and if applicable, only when they are not on the job.
☐ Training completed (person) ☐ Accompanied by: (not required)
☐ Training testing (AI) ☐ Accompanied by: (not required)

Examination Results
☐ Passing with no comment from
☐ Qualified by representative of (not required)
☐ Conditional Exam (not required)

The information I have provided supporting this physical examination is true and complete. I am a duly licensed Medical Examiner in the State of , and I am not in my office.

Medical Examiner's Signature

 Medical Examiner's Name (Please print or type)

 Address: City: State: Zip:

Medical Examiner's License Information
 License Number: State:
 License Type: (Please print or type)
 License Status: (Please print or type)
 National Registry Number:

Medical Examiner's Contact Information
 Phone: Email:
 Fax: Mobile:

Medical Examiner's Signature

 Medical Examiner's Name (Please print or type)

 Address: City: State: Zip:

Medical Examiner's License Information
 License Number: State:
 License Type: (Please print or type)
 License Status: (Please print or type)
 National Registry Number:

Medical Examiner's Contact Information
 Phone: Email:
 Fax: Mobile: