


WISCONSIN **COMMERCIAL DRIVER LICENSE** USA WI


 4d DL **K300-1726-4045-03**
1 **KIDD**
2 **DUANE LYLE**
3 **W5249 COUNTY ROAD G**
RIO, WI 53960


3 **DOB** **02/05/1964** 4b EXP **02/05/2023**

15 SEX **M** 4a ISS **01/26/2015**
16 HGT **6'-01"** 18 EYES **BRO**
17 WGT **240 lb** 19 HAIR **BRO**

9 CLASS **ABCDM**
9a END **NONE**

D. Kidd

5 **DD OTRUS2015012612445372** 



1502895108920914001

\$82.00
95108-920-914
BD01

02051964

www.wisconsinmvt.gov

CLASS: A-26,001 or more GVWR, actual or reg., AND towed unit over 10,000 GVWR; B-26,001 or more GVWR, actual or reg., towed unit 10,000 or less GVWR; C-HazMat placarded or designed to or carrying 16 or more people-Need H/P; D-Non-Commercial Vehicles; M-Motorcycles

Print Below. Use Permanent Ink.
Anatomical Gift Statement - Upon my death, I wish to donate:
☐ All organs, tissues or eyes. ☐ I refuse to make an anatomical gift.

Except:

Signature:

Date:

WI



Public Review Statement
 A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting burden for this collection of information is estimated to be approximately 1 minute per response, including the time for reviewing instructions, searching existing data sources, gathering the data needed, reviewing the collection of information, completing and reviewing the collection of information, sending the data to the Federal Motor Carrier Safety Administration, MC-HRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

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

I certify that I have examined **Last Name:** Kidd **First Name:** Duane 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

☐ 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 Signature
Dawn Faust

Medical Examiner's Name (please print or type)
Dawn Faust

Medical Examiner's Telephone Number
820-623-1200

Date Certificate Signed
12/06/2019

Medical Examiner's State License, Certificate, or Registration Number
3263-33

☐ MD ☐ Physician Assistant ☒ Advanced Practice Nurse

☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____

Issuing State
WI

National Registry Number
9166750292

Medical Examiner's Certificate Expiration Date
12/06/2021

Driver's Signature
Duane Kidd

Driver's Address
 Street Address: W5249 Cty Rd G City: Rio State/Province: WI Zip Code: 53960

Driver's License Number
K300-1726-4045-03

Issuing State/Province
WI

CLP/CDL Applicant/Holder
☒ Yes ☐ No

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