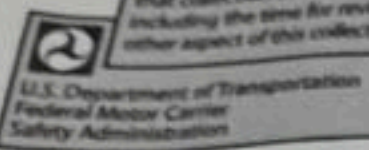


Form MCSA-5875

Public Burden 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 currently 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 one 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-PRA, 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:** Deloach **First Name:** Patrick 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 ☐ 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
08/18/2025

Medical Examiner's Signature 	Medical Examiner's Telephone Number <u>(786) 472-0230</u>	Date Certificate Signed <u>08/18/2023</u>
Medical Examiner's Name (please print or type) <u>Julio Cevalles Alcantara</u>	<input type="radio"/> MD <input type="radio"/> Physician Assistant <input checked="" type="radio"/> Advanced Practice Nurse <input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> Other Practitioner (specify) _____	
Medical Examiner's State License, Certificate, or Registration Number <u>APRN9377003</u>	Issuing State <u>Florida</u>	National Registry Number <u>9264895827</u>

Driver's Signature 	Driver's License Number <u>D420-663-69-138-0</u>	Issuing State/Province <u>Florida</u>
Driver's Address Street Address: <u>8301 NW 10TH AVE</u> City: <u>Miami</u> State/Province: <u>FL</u> Zip Code: <u>33150</u>	CLP/CDL Applicant/Holder <input checked="" type="radio"/> Yes <input type="radio"/> No	

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