

CALIFORNIA USA

COMMERCIAL  
DRIVER LICENSE

DL A4110063

EXP 06/04/2023

CLASS A  
END NONE

LN MEDINA

FN SIDNEY HENRY

PO BX 4024

SANTA FE SPGS, CA 90670

DOB 06/04/1971

RSTR NONE

DONOR

06041971

SEX M

HAIR BRN

EYES BRN

HGT 5'-11"

WGT 200 lb

DD 12/06/2017699D4/BBFD/23

SM71

ISS

12/28/2017



*S Medina*



**Public Burden Statement**

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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:** Medina **First Name:** Sidney 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

11/29/2021

Medical Examiner's Signature

*[Signature]*

Medical Examiner's Telephone Number

559-673-8888

Date Certificate Signed

11/29/2019

Medical Examiner's Name (please print or type)

Brent Gong

☐ MD

☐ Physician Assistant

☐ Advanced Practice Nurse

☐ DO

☒ Chiropractor

☐ Other Practitioner (specify)                     

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

22254, 2187578376

Issuing State

CA

National Registry Number

2187578376

Driver's Signature

*[Signature]*

Driver's License Number

A4110063

Issuing State/Province

CA

Driver's Address

Street Address: 11214 Clarkman Street

City: Santa Fe Spring

State/Province: CA

ZIP Code: 90670

☒ Yes ☐ No

CLP/CDL Applicant/Holder



Last Name: MEDINA First Name: SEANEY DOB: 06 04 1971 Exam Date: 11.29.2019

**DRIVER HEALTH HISTORY (continued)**

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

Other health condition(s) not described above:

☐ Yes ☒ No ☐ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below.

☐ Yes ☒ No ☐ Not Sure

(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: S. Med Date: 11.29.2019

**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).

No Problems

(Attach additional sheets if necessary)



Last Name: MEDINA First Name: SIDNEY DOB: 06 04 1971 Exam Date: 11.29.2019**TESTING**Pulse rate: 68 Pulse rhythm regular: ☒ Yes ☐ NoHeight: 5 feet 11 inches Weight: 200 pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting	<u>132</u>	<u>82</u>	Urinalysis is required. Numerical readings must be recorded.	<u>1.020</u>	<u>Neg</u>	<u>Neg</u>	<u>Neg</u>
Second reading (optional)							

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/ <u>50</u>	20/ <u>20</u>	Right Eye: <u>90</u> degrees
Left Eye:	20/ <u>40</u>	20/ <u>20</u>	Left Eye: <u>90</u> degrees
Both Eyes:	20/ <u>50</u>	20/ <u>20</u>	

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?

Yes No OR

☒ ☐ ☐**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

7 7**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**

1. General

2. Skin

3. Eyes

4. Ears

5. Mouth/throat

6. Cardiovascular

7. Lungs/chest

Normal Abnormal

☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐**Body System**

8. Abdomen

9. Genito-urinary system including hernias

10. Back/Spine

11. Extremities/joints

12. Neurological system including reflexes

13. Gait

14. Vascular system

Normal Abnormal

☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐☒ ☐

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.

No Problems

(Attach additional sheets if necessary)





CALIFORNIA DEPARTMENT OF MOTOR VEHICLES  
\*\*\*CUSTOMER RECEIPT COPY\*\*\*  
DRIVER LICENSE/IDENTIFICATION CARD\*  
INFORMATION REQUEST  
08/13/2020

DATE:08-13-20\*TIME:11:24\*  
DL/NO:A4110063\*  
B/D:06-04-1971\*NAME:MEDINA,SIDNEY HENRY\*  
MAIL ADD AS OF 01-03-18:PO BX 4024, SANTA FE SPGS 90670\*  
RES ADD:5318 N 6TH ST APT M, FRESNO\*  
OTH ADD AS OF 12-22-17:5318 N 6TH ST M, FRESNO\*  
IDENTIFYING INFORMATION:  
SEX:MALE\*HAIR:BROWN\*EYES:BRN\*HT:5-11\*WT:200\*  
ID CARD MLD:12-18-08\* EXP:06-04-14\*  
LIC/ISS:12-28-17\* EXP:06-04-23\*CLASS:A COMMERCIAL\*  
ENDORSEMENTS:  
NONE\*  
MEDICAL EXPIRES:11-29-21\*  
\*\* MORE \*\*

MEDICAL CERTIFICATE INFORMATION:  
ISSUE DATE: 11-29-19 EXPIRATION DATE: 11-29-21  
STATUS CODE: C  
MED EXAMINER NUMBER: CA 22254  
MED REGISTRY NUMBER: 2187578376  
SPECIALTY: CH MED EXAMINER PHONE NUMBER: 5596738888  
MED EXAMINER NAME:  
LAST NAME: GONG  
FIRST NAME: BRENT  
MED CERT RESTRICTIONS: 1  
SPE EFF DATE: NONE  
DRIVER WAIVER TYPE: NONE  
SELF CERTIFICATION INFORMATION:  
SELF CERTIFICATION CODE: NI  
\*\* MORE \*\*

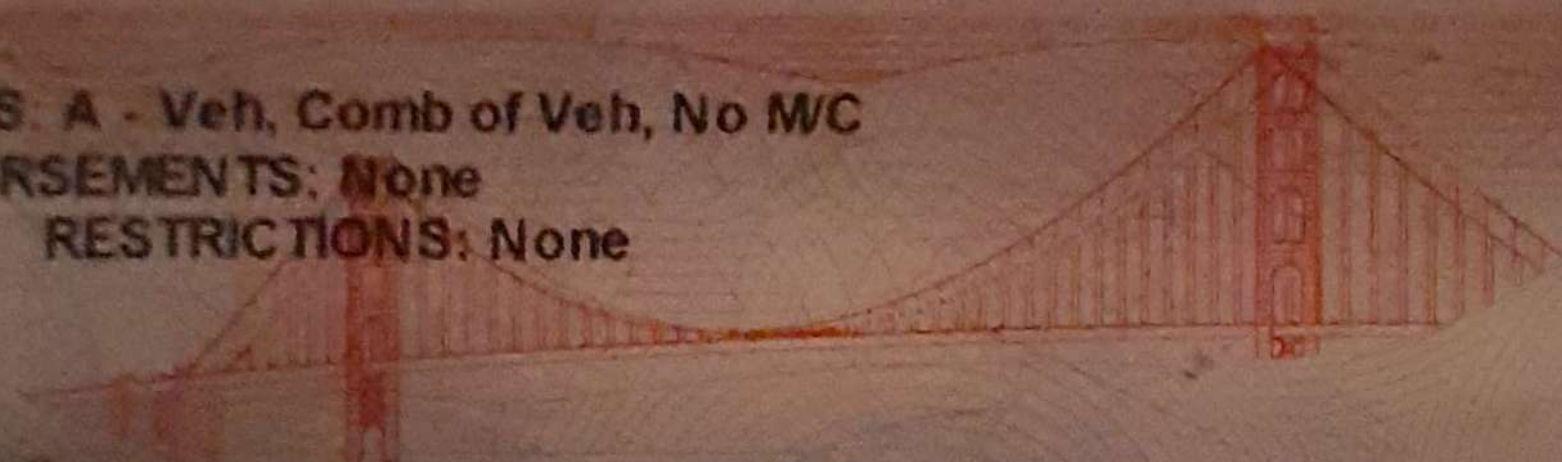
RESTRICTIONS:  
MUST WEAR CORRECTIVE LENSES WHEN DRIVING COMMERCIALY\*  
COMMERCIAL LICENSE STATUS:  
VALID\*  
LICENSE STATUS:  
VALID\*  
DEPARTMENTAL ACTIONS:  
NONE\*  
CONVICTIONS:  
NONE\*  
FAILURES TO APPEAR:  
NONE\*  
ACCIDENTS:  
\*\* MORE \*\*

NONE\*  
END

DMV FEE:	\$5.00
CREDIT CARD SERVICE FEE:	\$0.11
TOTAL:	\$5.11
PAYMENT TYPE:	VISA
ACCOUNT NUMBER:	9780
TRANSACTION NUMBER:	253-253678
DMV AUTHORIZATION NUMBER:	082514
CREDIT CARD AUTHORIZATION NUMBER:	082514



CLASS: A - Veh, Comb of Veh, No M/C  
ENDORSEMENTS: None  
RESTRICTIONS: None



This license is issued as a license to  
drive a motor vehicle; it does not  
establish eligibility for employment,  
voter registration or public benefits.

060471

*3401*

Rev 04/16/2010



# SOCIAL SECURITY CARD

561-17-3024

THIS NUMBER HAS BEEN ESTABLISHED FOR

SIDNEY HENRY  
MEDINA

*S. Medina*

SIGNATURE

10/22/2013

