

Form MCSA-5876 OMB No. 2126-0056 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 2126-0056. Public reporting burden for this collection of information is estimated to be approximately 1 minute per response, including the time for reviewing instructions, gathering the data needed, reviewing existing information, collecting the data, reviewing the collection of information, 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, 400 9th Street, NE, Washington, D.C. 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: Suarez Martinez** **First Name: Jorge** 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 encloses my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature _____ **Medical Examiner's Telephone Number** 321-219-0312 **Date Certificate Signed** 07/23/2019

Medical Examiner's Name (please print or type) Lorraine Weigand ☐ MD ☐ Physician Assistant ☒ Advanced Practice Nurse
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____
Medical Examiner's State License, Certificate, or Registration Number APN 9379098 **Issuing State** FL **National Registry Number** 86354990000

Driver's Signature *[Signature]* **Driver's License Number** S625-426-97-339-0 **Issuing State/Province** FL **CLP/CDL Applicant/Holder** Yes ☒ No ☐

Driver's Address 613 N Hastings St **City** Orlando **State/Province** FL **Zip Code** 32801

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.

