

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 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 the collection of information, and completing and reviewing the collection of information. Send comments regarding this burden estimate and other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Project, Department of Transportation, Washington, DC 20590.

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examiner's Certificate

(By Commercial Driver's License Examiner)

I certify that I have examined **Last Name: LAZARE** **First Name: Redusue** 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 variations (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 intrastate 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

10-15-2023

Medical Examiner's Signature

Medical Examiner's Name (please print or type)

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

Medical Examiner's Telephone Number

Date Certificate Signed

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

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

Street Address:

901 NW 195 Th St

City:

MIAMI

State/Province:

FL

Zip Code:

33169

D.P. CDL Applicant/Holder

Yes ☐ No ☒

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