OMB No. 2126-0006 Expiration Date: /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. ... of information is estimated to be approximately ... Information Collection ... Officer, ...

...partment of Transportation
... Motor Carrier ... Administration

APPROVED

Medical Examination Report Form
(for Commercial Driver Medical Certification)

(or sticker)

SECTION 1. Driver Information *(to be filled out by the driver)*

PERSONAL INFORMATION

Last Name: Hathorn First Name: Kenneth Middle Initial: H Date of Birth: 2-7-67 Age: 53

Street Address: P.O Box 7211 City: Monroe State/Province: LA Zip Code: 71202

Driver's License Number: 009068527 Issuing State/Province: LA Phone: 318) 351-0820 Gender: ⦿ M ○ F

E-mail *(optional)*: Hawthornexpress@gmail.com CLP/CDL Applicant/Holder*: ⦿ Yes ○ No

Driver ID Verified By**: [signature]

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ○ Yes ⦿ No ○ Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ○ Yes ⦿ No ○ Not Sure

NO

Are you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? If "yes," please describe below. ○ Yes ⦿ No ○ Not Sure

No

(Attach additional sheets if necessary)

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Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Kenneth First Name: Hathorn DOB: 2-7-67 Exam Date: 10/27/20

DRIVER HEALTH HISTORY (continued)

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

Other health condition(s) not described above: ○ Yes ✓ No ○ Not Sure

No No

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 any 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: Kenneth Hathorn Date: 10/27/20

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).

Ø RX / Medical

(Attach additional sheets if necessary)

Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Hathorn First Name: Kenneth DOB: 2/7/67 Exam Date: 10/27/20

TESTING

Pulse rate: 83 Pulse rhythm regular: ☒ Yes ○ No Height: 6 feet 1 inches Weight: 270 pounds

Blood Pressure	Systolic	Diastolic
Sitting	126	83
Second reading (optional)		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1025	NEG	NEG	NEG

Other testing if indicated

BUN 34.0 02 98% Hct 45.5%

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/___	20/25	Right Eye: >70 degrees
Left Eye:	20/___	20/30	Left Eye: >70 degrees
Both Eyes:	20/___	20/25	

	Yes	No
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?	○	☒

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

Record distance *(in feet)* from driver at which a forced whispered voice can first be heard

Right Ear	Left Ear
>5ft	>5ft

OR

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	Normal	Abnormal	Body System	Normal	Abnormal
1. General Obese	☒	○	8. Abdomen	☒	○
2. Skin	☒	○	9. Genito-urinary system including hernias	☒	○
3. Eyes	☒	○	10. Back/Spine	☒	○
4. Ears	☒	○	11. Extremities/joints	☒	○
5. Mouth/throat	☒	○	12. Neurological system including reflexes	☒	○
6. Cardiovascular	☒	○	13. Gait	☒	○
7. Lungs/chest	☒	○	14. Vascular system	☒	○

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.

(Attach additional sheets if necessary)

Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: [redacted]Hathorn Kenneth First Name: Kenneth DOB: 2/7/67 Exam Date: 10/27/20

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- ○ Does not meet standards *(specify reason)*: _____
- ☒ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ○ Meets standards, but periodic monitoring required *(specify reason)*: _____

Driver qualified for: ○ 3 months ○ 6 months ○ 1 year ○ other *(specify)*: _____

- ☒ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*: _____
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 *(Federal)*
- ☐ Driving within an exempt intracity zone (see 49 CFR 391.62) *(Federal)*
- ☐ Determination pending *(specify reason)*: _____
  - ☐ Return to medical exam office for follow-up on *(must be 45 days or less)*: _____
  - ☐ Medical Examination Report amended *(specify reason)*: _____

(If amended) Medical Examiner's Signature: _____ Date: _____

- ☐ Incomplete examination *(specify reason)*: _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: KDen

Medical Examiner's Name *(please print or type)*: Racolesha Denson, NP-C

Medical Examiner's Address: 1777 Ellis Ave City: Jackson State: MS Zip Code: 39204

Medical Examiner's Telephone Number: (601) 371-0400 Date Certificate Signed: 10/27/20

Medical Examiner's State License, Certificate, or Registration Number: 901779 Issuing State: MS

☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☒ Advanced Practice Nurse

☐ Other Practitioner *(specify)*: _____

National Registry Number: 9261530550 Medical Examiner's Certificate Expiration Date: 10/27/22

Form MCSA-5876

OMB No. 2126-0006 Expiration Date: 11/30/2021

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:** Hathorn **First Name:** Kenneth 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
☐ Wearing hearing aid
☐ Accompanied by a ________ waiver/exemption
☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
☐ 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: 10/27/22

Medical Examiner's Signature: KD [signature]

Medical Examiner's Telephone Number: 601-371-0400

Date Certificate Signed: 10/27/20

Medical Examiner's Name *(please print or type)*: Racolesia R. Denson

○ MD ○ DO ○ Physician Assistant ○ Chiropractor ◉ Advanced Practice Nurse ○ Other Practitioner *(specify)* ________

Medical Examiner's State License, Certificate, or Registration Number: 901779

Issuing State: Mississippi

National Registry Number: 8361529559

Driver's Signature: Kenneth Hathorn [signature]

Driver's License Number: 009068527

Issuing State/Province: LA

Driver's Address
Street Address: P.O Box 7211 City: Monroe State/Province: LA Zip Code: 71202

CLP/CDL Applicant/Holder ◉ Yes ○ No

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MEA Medical Clinics

Do you have a history of the following:

☑YES ☐NO Do you wear contacts or glasses to drive (If YES, you must have contacts/glasses during physical) The standard is 20/40 acuity in each eye with/without correction, or you will be disqualified.

☐YES ☑NO Blood Pressure problems

☐YES ☑NO Currently taking any Blood Pressure medications.
If yes, list medications + strength: _____
If yes, list name of prescribing Doctor and address:
_____

If Blood Pressure is above 140/90, you will be disqualifled

☐YES ☐NO Heart Problems
☐YES ☐NO Myocardial Infarction/MI
☐YES ☐NO Stent Placement
☐YES ☐NO Coronary Artery Bypass Graft Surgery (CABG)
☐YES ☐NO Murmur
☐YES ☐NO Angina

If YES to any question in this section, you must bring a Clearance Letter from your Cardiologist every year. Clearance letter dated within 30 days of Physical.
Every 2 years, you need an exercise tolerance test.

☐YES ☐NO Neurological problems
☐YES ☐NO Epilepsy
☐YES ☐NO Currently taking Anti-Seizure medications
If yes, list medications + strength: _____
☐YES ☐NO Seizures
☐YES ☐NO Stroke

If YES to any question in this section, you must bring a Clearance Letter from your Neurologist. Clearance letter dated within 30 days of Physical.

☐YES ☐NO Diabetic
If yes ,list medications + strength: _____
☐YES ☐NO Hemoglobin A1C (HBA1C) is less than 10

If Blood Glucose is greater than 200 or Urinalysis is positive for sugar, you can pay for us to perform a lab test or you can bring a Clearance letter from your Doctor that shows your A1C is less than 10 and performed within 30 days. ($30 MEA COST)

☐YES ☐NO Sleep Apnea
☐YES ☐NO Currently using a CPAP machine

If YES to any question in this section, you must bring a Clearance Letter from your Pulmonologist. Need proof of compliance with CPAP from Pulmonologist dated within 30 days of Physical.

☐YES ☐NO Currently talking Coumadin (INR 2-3 within 30 days)
☐YES ☐NO Currently taking any Narcotic medications (Clearance Letter required from your prescribing MD dated within 30 days of Physical)
☐YES ☐NO Currently taking any Habit-Forming medications (Clearance Letter required from your prescribing MD dated within 30 days of Physical)
☐YES ☐NO Currently taking any Psychotropic medications (Clearance Letter required from your prescribing MD dated within 30 days of Physical)
☐YES ☐NO Currently taking any other medications you have not listed
If YES, list medications + strength _____

Patient signature: × _____ Date: × 10/27/20

✓ If you start your physical and are DISQUALIFIED, you or your employer will still be responsible for payment.

EPWORTH SLEEPINESS SCORE

How likely are you to dose off or fall asleep in the following situations?

Please use the following scale to answer the phrases below.
Rate each situation and add your responses.

0 Would never doze
1 Slight chance of dozing
2 Moderate change of dozing
3 High chance of dozing

Fill out every line

0 Sitting and reading

0 Watching television

0 Sitting inactive in a public place

0 While a passenger in a car without a break

2 Lying down to rest in the afternoon when Circumstances permit

0 Sitting and talking to someone

0 Sitting quietly after a lunch without alcohol

0 In a car, while stopped in traffic for a few minutes

2 : **Total Epworth Score**

MEA Medical Clinics
Berlin Questionnaire
SLEEP EVALUATION

Name Kenneth Hathorn
Address PO Box 1217
Monroe, LA 71202

1 Complete the following:
height _____ age _____
weight _____ male/female _____

CATEGORY 1

2 Do you snore?
- ☐ yes
- ☑ no
- ☐ don't know

If you snore:

3 Your snoring is?
- ☐ slightly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms.

4 How often do you snore?
- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☑ never or nearly never

5 Has your snoring ever bothered other people?
- ☐ yes
- ☑ no

6 Has anyone noticed that you quit breathing during your sleep?
- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☑ never or nearly never

CATEGORY 2

7 How often do you feel tired or fatigued after your sleep?
- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☑ never or nearly never

8 During your wake time, do you feel tired, fatigued or not wake up to par?
- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☑ never or nearly never

9 Have you ever nodded off or fallen asleep while driving a vehicle?
- ☐ yes
- ☑ no

If yes, how often does it occur?
- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☑ never or nearly never

CATEGORY 3

10 Do you have high blood pressure?
- ☐ yes
- ☑ no
- ☐ don't know

BMI = %

Scoring Questions: Any answer within box outline is a positive response.
Scoring Categories: Category 1 is positive with 2 or more positive responses to questions 2-6
Category 2 is positive with 2 or more positive responses to questions 7-9
Category 3 is positive with 1 or more positive responses and/or a BMI>30
Final Results: 2 or more positive categories indicates a high likelihood of sleep disordered breathing.

Primary Care Plus
a service of St. Dominic's

OCCUPATIONAL/INDUSTRIAL AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL INFORMATION

Kenneth A Hathorn
(Name of person being treated/examined)

_____
(Authorizing Company)

I authorize this clinic and any medical group or their agents, employees and others working with them or in privity with them, involved with my medical treatment and or physical examination on this day, to release any and all information or results related to this treatment/examination to the Authorizing Company and/or persons designated by the company.

I do hereby affirmatively waive on behalf of myself and any persons who may have an interest in this matter all provisions of law relating to the disclosure of information acquired through the medical treatment of physical examination process, including, but not limited to, all written reports and other documentation of my individual medical treatment or physical examination results.

I certify that I have read and understand the matters contained in this Authorization and Consent for Release of Medical information and I further certify that I have executed this Authorization of my own free will and accord.

10/27/20
Date

Kenneth Hathorn
Signature of person being treated/examined

10/27/20
Date

Witness

HATHORN, KENNETH - Authorization For Service

CMS Order# A292393 **Expires 10/27/2020 11:59 PM**

Test Information

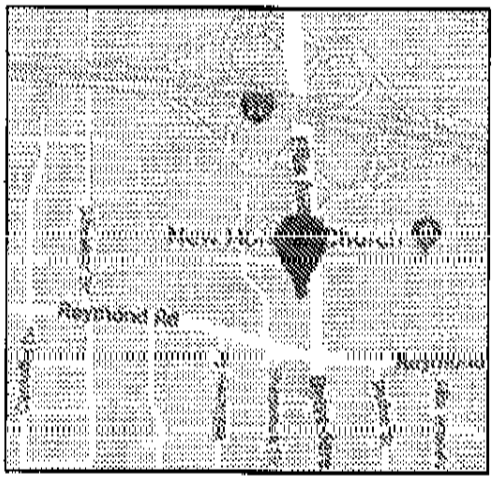
Name HATHORN, KENNETH
ID LA 009068527

Company Dart Transit
DER Besse, Randy
phone: 651-683-1606

Walk-In Tuesday October 27, 2020
Reason Recertification
Services Requested > **DOT Physical**
- Contact CMS immediately if a Certified Medical Examiner will not be available

Collection Site

MEA Primary Care Plus - South
1777 Ellis Avenue
Jackson, MS 39204
phone: 601-371-0400 fax: 601-371-1533



Donor Instructions Bring ID and plan to arrive at collection site at least 3 hours prior to closing
Please call to confirm hours of operation of: M-F 9:00am-5:00pm / PE WI by 4:00pm

Clinic Instructions If there are any issues with the testing such as refusal to test or contact the company DER and CMS immediately.

After Service Is Complete

To ensure prompt payment: Clinic is responsible for obtaining all required releases and sending documentation to email: Docs@CorporateMedicalServices.com or **fax:** (423) 870-7880

Invoicing Instructions:

Invoice CMS at the following address for all requested services ---->

EXCEPTION: All Quest Preferred sites and eScheduled orders should be billed to the contracted party

Corporate Medical Services, Inc.
5490 Dayton Blvd.
Chattanooga, TN. 37415
Billing@CorporateMedicalServices.com