Form MCSA-5876

OMB No. 2126-0006 Expiration Date: 8/31/2018

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 2126-0006. Public reporting for this collection of information is estimated to be approximately 1 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-RRA, 1200 New Jersey Avenue, SE, 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:** Frazile **First Name:** Emmanuel 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 .

☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*

☐ Wearing hearing aid ☐ 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 andcomplete. 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 7/5/2025

Medical Examiner's Signature DC **Medical Examiner's Telephone Number** 954-543-4858 **Date Certificate Signed** 7/5/2024

Medical Examiner's Name (please print or type) Dr. Orlando Agila

○ MD ○ Physician Assistant ○ Advanced Practice Nurse
○ DO ● Chiropractor ○ Other Practitioner *(specify)* _____

Medical Examiner's State License, Certificate, or Registration Number CH 8314 **Issuing State** FL **National Registry Number** 8410374681

Driver's Signature Emmanuel Frazile **Driver's License Number** F626200923700 **Issuing State/Province** FL

Driver's Address
Street Address: 1488 NW 52nd Ct City: Lauderhill
State/Province: FL Zip Code: 33313

CLP/CDL Applicant/Holder
● Yes ○ No

OMB No.: 2126-0006 Expiration Date: 03/31/2025

Name: Enriquez First Name: Fredie DOB: 10/30/1992 Exam Date: 07/5/24

TESTING

Pulse Rate: 80 Pulse rhythm regular: ◉ Yes ○ No

Height: 6 feet 0 inches Weight: 420 pounds

Blood Pressure	Systolic	Diastolic
Sitting	148	92
Second reading (optional)		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.020	(-)	(-)	(-)

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Other testing if indicated

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
Right Eye:	20/ 30	20/
Left Eye:	20/ 25	20/
Both Eyes:	20/ 30	20/

Horizontal Field of Vision
Right Eye: 90 degrees
Left Eye: 90 degrees

	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
6	6

OR

Audiometric Test Results

Right Ear: 500 Hz	1000 Hz	2000 Hz	Left Ear: 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
1. General	◉	○
2. Skin	◉	○
3. Eyes	◉	○
4. Ears	◉	○
5. Mouth/throat	◉	○
6. Cardiovascular	◉	○
7. Lungs/chest	◉	○
8. Abdomen	◉	○
9. Genito-urinary system including hernias	◉	○
10. Back/spine	◉	○
11. Extremities/joints	◉	○
12. Neurological system including reflexes	◉	○
13. Gait	◉	○
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.

OA

(Attach additional sheets if necessary)

Other health condition(s) not described above:

Emmanuel Frasile

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

Emmanuel Frasile

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 [redacted], and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under [redacted] and [redacted]. Appendix A and B.

Driver's Signature: Emmanuel Frasile Date: 07/5/24

SECTION 2. Examination Report (to be filled out by the medical examiner)

DRIVER HEALTH HISTORY REVIEW

Review and discuss certified driver answers and any available medical records. Comment on the driver's responses in the "health history" section that may affect the driver's safe operation of a commercial motor vehicle (CMV).

DA Emmanuel

Form MCSA-5875

OMB No.: 2126-0006 Expiration Date: 03/31/2025

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

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #

_____

(or sticker)

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

PERSONAL INFORMATION

Last Name: Frazile First Name: Immanuel Middle Initial: ___ Date of Birth: 10/30/92 Age: 31

Street Address: 1480 NW 52nd City: Lauderhill State/Province: FL Zip Code: 33313

Driver's License Number: F4242009239902 Issuing State/Province: Florida Phone: 9548394871

E-Mail *(optional)*: Efrazile@yahoo.com CLP/CDL Applicant/Holder*: ◉ Yes ○ No

Driver ID Verified By**: O.A

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

d

...ently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? ○ Yes ◉ No ○ Not Sure

OMB No.: 2126-0006 Expiration Date: 03/31/2025

Name: Frazile First Name: Emmanuel DOB: 10/30/90 Exam Date: 07/5/24

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)*: HTN

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: [signature]

Medical Examiner's Name *(please print or type)*: Dr. ORLANDO AGUILA, D.C.

Medical Examiner's Address: 7060 TAFT STREET City: HOLLYWOOD State: FL Zip Code: 33024

Medical Examiner's Telephone Number: (954) 543-5448 Date Certificate Signed: 7/5/2024

Medical Examiner's State License, Certificate, or Registration Number: CH 8314 Issuing State: FL

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

☐ Other Practitioner *(specify)*: _____

Medical Examiner's Certificate Expiration Date: 7/5/2025

National Registry Number: 8910399681