

**COMMERCIAL  
DRIVER LICENSE**

*Tennessee*  
THE VOLUNTEER STATE

USA  
TN



*Nathaniel R. Reppond*

DL NO. **114050148** DOB **11/13/1986**

EXP **09/05/2025** ISS **09/05/2017**

CLASS **A** END **NONE**

REST **NONE**

SEX **M** HGT **5'-06"** EYES **BLU**

DD **8201709051129987**

**CDL**

**REPPOND  
NATHANIEL RYAN  
2217 GLENBURN RD  
LOT 6  
KINGSPORT, TN 37660-7645**

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: Reppond** **First Name: Nathaniel** 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**

**8/24/22**

**Medical Examiner's Signature**

*[Signature]*

**Medical Examiner's Telephone Number** **Date Certificate Signed**

**81041460400**

**8/24/20**

**Medical Examiner's Name** (please print or type)

**Domina, Joe**

☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse

☒ DO ☐ Chiropractor ☐ Other Practitioner (specify) \_\_\_\_\_

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

**5101009015**

**Issuing State**

**MI**

**National Registry Number**

**942046627**

**Driver's Signature**

*[Signature]*

**Driver's License Number**

**114050148**

**Issuing State/Province**

**TN**

**Driver's Address**

**2217 Glenburn Rd**

**CLP/CDL Applicant/Holder**

**City: Kingsport**

**State/Province: TN**

**Zip Code: 37604**

**Yes ☒ No ☐**

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