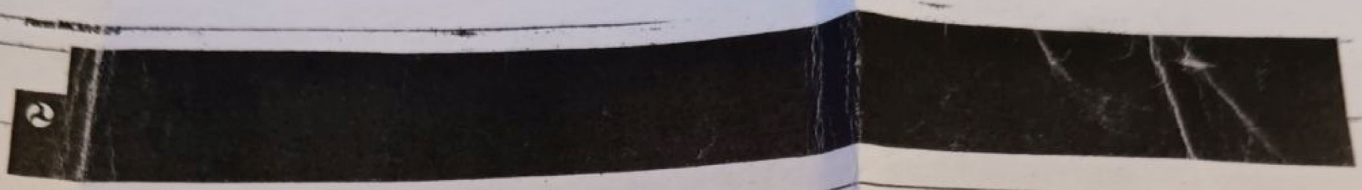

I certify that I have examined **Last Name:** Turner **First Name:** Robert in accordance with *(please check only one)*:

☑ 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: 10/22/2024

Medical Examiner's Signature PRhoades NP

Medical Examiner's Telephone Number 6275555

Date Certificate Signed 10/22/2022

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

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

Medical Examiner's State License, Certificate, or Registration Number: NP15722

Issuing State: California

National Registry Number: 9331135443

Driver's Signature

Driver's License Number: T656-7606-8085

Issuing State/Province: Illinois

Driver's Address

Street Address: 319 E. ~~Acacia~~ Vernon Ave City: Normal State/Province: IL Zip Code: 61761

CLP/CDL Applicant/Holder: ☑ Yes ○ No

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