

Public Burden Statement

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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: CHAVEZ BECERRA First Name: ALEXIS Middle Initial: Date of Birth: 10/09/1973 Age: 50
Street Address: 605 WOODLAWN DR City: SEBRING State/Province: FL Zip Code: 33870
Driver's License Number: C121000733690 Issuing State/Province: Florida Phone: (786) 661-7001
E-Mail (optional): ACH2632@GMAIL.COM CLP/CDL Applicant/Holder*: ☒ Yes ☐ No
Driver ID Verified By**: LICENSE
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 SureAre you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)?
If "yes," please describe below.☒ Yes ☐ No ☐ Not SureLISINOPRIL

(Attach additional sheets if necessary)

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