

Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 12/31/2024

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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: Perez Montero First Name: Joan 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

02/23/2024

Medical Examiner's Signature

Medical Examiner's Name (please print or type)

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

Medical Examiner's Telephone Number

(961) 969-1595

Date Certificate Signed

02/23/2024

☒ MD ☐ Physician Assistant ☐ Advanced Practice Nurse  
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify)

Issuing State

FL

National Registry Number

8A73944905

Driver's Signature

Driver's Address

Street Address

Driver's License Number

(Aptc) P625969750070

State/Province

FL

CLP/CDL Applicant/Holder

☒ Yes ☐ No

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