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 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 25 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the 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

Medical Examination Report Form

				M	MEDICAL RECORD #
CTION 1. Driver Informa	ation (to be filled out by the o	driver)		an Act of	(or sticker)
ERSONAL INFORMATION	ACCURATE A CONTRACTOR OF THE SECOND S	angues es a sacc			
ast Name: Bentson	First Name:	Curtis	Middle Initial:	Date of Birth:	
treet Address: 17600 N	N 79th Ave	City: Glend	ale	State/Province	
river's License Number: mail (optional):	D10606542	Issuing State/Provin	ce: <u>AZ</u> Phor P/CDL Applicant/Holder	-	Television of the second
man (optional).			ver ID Verified By**:	Drivers License	
				⊙Yes ONo	
as your USDOT/FMCSA m	iedical certificate ever been	denied or issued for less tha			the identity of the driver, e.g., CDL, driver's license, pa
/CDL Applicant/Holder: See Instructions for definiti	cions.	0.000			
RIVER HEALTH HISTORY		The Marian Control	A TO THE STREET		OYes ⊙No ONot Sure
Are you currently taking m f "yes", please describe be	nedications (prescription, ove clow.	er-the-counter, herbal remedie	rs, diet supplements)?		⊙Yes ONo ONot Sure
f "yes", please describe be Amlodipine Hydrochlothorizide	low.	er-the-counter, herbal remedie			

(Attach additional sheets if necessary)

Page 1

^{**}This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.**

Last Name:	Bentson		First Name:	Cu	ırtis		DOB: 04/16/1981 Exam Date: 12	/16/20	021	
DRIVER HEAL	TH HISTO	RY(continued)		ewant.		70			Heat .	
Do you have			Minneson de la Constitución de l			Not	the state of the s	Yes N		Not
1. Head/brai	in injuries o	or illnesses (e.g., concuss	ion)	Yes	No S	_		-	• ⊙	0
2. Seizures,	enilansy	i ililiesses (e.g., concuss	ion)	0	0	0	 Dizziness, headaches, numbness, tingling, or memory loss 	0	O	U
	-	glasses or contacts)		0	0	0	17. Unexplained weight loss	0	0	0
				0	0	0	18. Stroke, mini-stroke (TIA), paralysis, or weakness	0	0	0
4. Ear and/o				0	0	0	19. Missing or limited use of arm, hand, finger, leg, foot, toe	0	0	0
problems	ase, heart a	attack, bypass, or other	heart	0	0	0	20. Neck or back problems	0	0	0
6. Pacemake	er, stents, in	nplantable devices, or o	other heart	0	0	0	21. Bone, muscle, joint, or nerve problems	0	0	0
7. High bloo				_	_	_	22. Blood clots or bleeding problems	0	0	0
8. High chol				0	0	0	23. Cancer	0	0	0
100 000 000 000 000				0	0	0	24. Chronic(long-term)infection or other chronic diseases	0	0	0
breathing	problems	cough, shortness of bre	ath, or other	0	0	0	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	0	0	0
10. Lung dise				0	0	0	26. Have you ever had a sleep test (e.g., sleep apnea)?	0	0	0
11. Kidney pr urination	oblems, kid	Iney stones, or pain/pro	oblems with	0	0	0	27. Have you ever spent a night in the hospital?	õ	Õ	ŏ
		gestive problems		0	0	0	28. Have you ever had a broken bone?	O	0	0
				0	_	_	29. Have you ever used or do you now use tobacco?	0	0	0
		gar problems		0	0	0	30. Do you currently drink alcohol?	0	0	Ö
Insulin				0	0	0	31. Have you used an illegal substance within the past two	•	0	0
problems	lepression,	nervousness, other me	ntal health	0	0	0	years?	•		_
15. Fainting o	or passing o	out		0	0	0	32. Have you ever failed a drug test or been dependent on an illegal substance?	0	0	0
		Control Control					of the Mark Control Statement of the Control S			
Did you answ		<u> </u>	If so, please co	omme	ent fu	irther	on those health conditions below. Yes O No	ONG	ot Sui	re
September 1			-	_			(Attach additional sheets if nec			\Box
CMV DRIVER	E CICNATI	line.			- 1-		(Attach daditional sheets if nee	essury	"	- 12 2
provider from the County County	Well on Advantage with	and the desire the desire			فللصنف	er ce	alan and a second secon			
and my Medi	cal Examine or intention	er's Certificate, that sub	mission of frau	duler	nt or i	inten	at inaccurate, false or missing information may invalidate the tionally false information is a violation of <u>49 CFR 390.35</u> , and inal penalties under <u>49 CFR 390.37</u> and <u>49 CFR 386</u> Appendi Date: 12/16/2021 1:15:13 PM	that s	ubmi	ission
SECTION 2.1	Examinatio	n Report (to be filled o	ut by the medic	al exc	mine	er)				
DRIVER HEA	LTH HISTO	RY REVIEW		i.			T and the second	1)4	- Ala	
Review and dis driver's safe op	cuss pertine eration of a	nt driver answers and any commercial motor vehicl	v available medi e (CMV).	cal re	cords.	Com	ment on the driver's responses to the "health history" questions tha	t may	affect	the
Medication	ns Comment	ts - same; Q7 - sa	me; no othe	r me	ds p	robs				
							(Attach additional sheets if n	ecesso	ıry)	

Last Name:	Bentson		First Name:	Curtis	5		DOB:	04/10	5/1981	Exam C	Date: 12/1	6/2021
Testing			was est to see		Sec.	PRODUCT !	,	TO POST OF		Marie of the		
Pulse rate:	88 F	Pulse rhythm regu	lar: • Yes	ONo) F	leight: _5	feet _	1_inci	hes Weig	ht: 179 pc	ounds	
Blood Pres	sure Systoli	ic	Diastolic	and the second	1/481	Urinal		1.786	Sp. Gr.	Protein	Blood	Sugar
Sitting	136		94	-	-	Urinals	sis is requi	ired.	1.015	Negative	Negative	Negative
Second read (optional)	ding 134		86	10.2	_	Nume	rical readin be recorded	gs			Negaure	
Other testing	if Indicated	L.			_	Protein,	blood, or su	ugar In ti	he urine ma	y be an Indic	ation for furth	er testing to
1000		Li Vepeer i	and the L	Autom	-	rule out	any underl	ylng me	dical proble	m.		
	east 20/40 acuity (Si vision in horizonta ould be noted on th			correction he use of	n. At s	learing tandard: N earing los	Aust first per s of less than	rceive wi	hispered vo al to 40 dB,	lce at not less in better ear (than 5 feet O with or withou	R average at hearing aid).
Acuity	Uncorrected	Corrected Ho	rizontal Field	of Vision			earing aid (r test: 🔲 F	Right Ear 🔲	Left Ear Right Ea	☑ Neither Left Ear
Right Eye:	20/_30	20/ Rigi		degree	,					which a forc		
Left Eye:	20/_40	20/ Left		degree	. v	vhispered O R	l voice can	first be	heard		5	_ 5
Both Eyes:	20/ 30	20/	70 - 101	Yes No	_		ric Test Re	sults				
Applicant can	recognize and dis	stinguish among t	raffic control	0	_	ight Ear	ine reseme			Left Ear		
Monocular vis	evices showing red	d, green, and amb	er colors	0	o 5	00 Hz	1000 Hz	200	0 Hz	500 Hz	1000 Hz	2000 Hz
Referred to op	hthalmologist or	optometrist?			。 -	4-1-	144					
	umentation from		or optometrist	_	_	verage (ri	ght):			Average (le	ft):	
PHYSICAL EX	AMINATION	1.75				ings.					47 P. P. P.	
is readily ame Also, the drive result in a mo	of a certain condi nable to treatmer er should be advis re serious illness t dy systems for abi	nt. Even if a condit sed to take the nec that might affect d	ion does not o essary steps t	disqualify	a driv	er, the M	edical Exan	niner m	ay conside	r deferring t	he driver ter	nporarily.
Body System	1		Norm	al Abr	normal	Body					Normal	Abnormal
1. General 2. Skin			0		0		odomen				0	0
3. Eyes			0		00		enito-urina ick/Spine	ry syste	m includin	g hernias	0	0
4. Ears			ŏ		ŏ		tremities/j	oints			⊙	0
5. Mouth/thr			0		0		eurological	system	including	reflexes	ŏ	ŏ
6. Cardiovaso			0		0	13. G					•	00000
7. Lungs/che Discuss any al	onormal answers in	detail in the space b	⊙ selow and indic	ate whet	O her It w		scular syst t the driver's		o operate a	CMV	•	0
Enter applicat	le item number bef	ore each comment.					· tric direct	, domity t	оорегите	CMF.		
			.,						(Attac	h additional	sheets if nece	ssary)

Last Name:	Bentson	First Name:	Curtis	DOB:	04/16/1981	Exam Date:	12/16/2021
Please compl	ete only one of the following (Fed	ieral or State) M	edical Exa	miner Determination :	sections:		
MEDICAL EX	MINER DETERMINATION (Feder	ral)			· · · · · · · · · · · · · · · · · · ·		
Use this section	n for examinations performed in ac	cordance with th	e Federal N	lotor Carrier Safety Regu	ulations (49 CFR 391,4	1-391.49):	
	meet standards (specify reason):					1	
O Meets sta	ndards in <u>49 CFR 391.41;</u> qualifies	for 2-year certific	cate				11
	ndards, but periodic monitoring r	equired (specify i	reason):	htn			
Driver qu	alified for: O 3 months O	6 months	1 year	O other (specify):			
	orrective lenses			nied by a waiver/exem	ption (specify type):		
☐ Accompa	nied by a Skill Performance Evalua	tion (SPE) Certifi	cate	☐ Qualified by op	eration of 49 CFR 39	<u>1.64</u> (Federal)	
	thin an exempt intracity zone (see	49 CFR 391.62) (Federal)				
☐ Determina	ation pending (specify reason):	CT()					
Return	to medical exam office for follow	-up on (must be	15 days or le	ess):			
☐ Medica	l Examination Report amended (specify reason):					
	(if amended) Medical Examiner's S	ignature:			Date:		
☐ Incomple	te examination (specify reason):						
If the d	river meets the standards outlined i	n <u>49 CFR 391.41</u> , t	hen comple	te a Medical Examiner's (Certificate as stated in	49 CFR 391.43(h), as appropriate.
I have perform and attest tha	ned this evaluation for certificatio t, to the best of my knowledge, I l	n. I have persona believe it to be tr	ally reviewe	ed all available records rect.	and recorded inform	nation pertainin	g to this evaluation,
Medical Exam	niner's Signature:	7					
Medical Exam	niner's Name (please print or type):	Banasta	ak, Rosalle				
Medical Exam	niner's Address: 12808 N Bla	ck Canyon Hwy		ity: Phoenix	State:	AZ Zip	Code: 85029-1346
Medical Exam	niner's Telephone Number:	(602)375-1155	D	ate Certificate Signed:	12/16/2021		
Medical Exam	niner's State License, Certificate, o	r Registration Nu	ımber:	15037		Issuing :	State: AZ
☑ MD □	DO Physician Assistant	☐ Chiropractor	☐ Adva	anced Practice Nurse			
Other Pra	ctitioner (specify):					A STATE	
National Reg	stry Number: <u>8249600872</u>			Medical Examiner's Co	ertificate Expiration I	Date: <u>12</u>	/16/2022

Additional Notes Addendum

Last Name: Bentson	First Name: Curtis D	OB: 04/16/1981	Exam Date: 12/16/2021
RIVER HEALTH HISTORY			
Surgery (continued):			
			1
THE CONTRACTOR OF SECTION			
Medications (continued):			
Amlodipine Hydrochlothorizide			
(B) 7 (B) (LE (B) (B))			
Health History Yes Answers(continued):			1 1
27 - Hypertension ;			
Other Health Conditions (continued):			
Examiner Comments (continued):			
Medications Comments - same; Q7 - sam	ne; no other meds probs		
HYSICAL EXAMINATION		Saiders	
			1 11
THER TESTING			
Glucose Meter Measurements (mg/dl):	and the state of t	to the state of th	Andrew Control of the
Neck Circumference: (Inches): 15.5			
BMI: 33.8			
Additional comments for abnormal urine v	values:		

Last Name:	Bentson		First Name:	Curtis		DOB: 0	4/16/1981	Exam Date:	12/16/2021
ERTIFICATION	NC						II III	1 1112	
and the second control of the second	et Standards (con								A CONTRACTOR
	or orangards (con	unded).			17	+			
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htn	quired due to (∞r	ntinued):		1					
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Reason Text	(continued):	1 - 5			1 3	12		1	1 7 7
	120	1 5 5 5							4. 6:
		9.5			0.00			7	71 11
							. 4 2		

miner's Certificate		andatory. Send comments regarding RRA, 1200 New Jersey Avenue, SE, W	perwork Reduction Act unles imately 1 minute per respons g this burden estimate or any lashington, D.C. 20590.
al Driver Medical Certification)			
of the driving duties, I find this ate variances (which will only b	person is qualified, and, if a e valid for intrastate opera	applicable, only when (check ations), and, with knowledge	all that apply) OR of the driving duties,
Certificate Qualified b	y operation of 49 CFR 391.	64 (Federal)	
complete Medical Examination file in my office.		Medical Examiner's Certific 12/16/202	•
	s Telephone Number	Date Certificate Signe	ed
_	_		
Issuing State AZ	actor Other	National Registry Nun 8249600872	nber
Driver's License No	umber	Issuing State/Province	е
D10606542		AZ	
State/Prov			OL Applicant/Holder O No
-	of the driving duties, I find this tate variances (which will only be aption	ne	in accordance with (please check only one): of the driving duties, I find this person is qualified, and, if applicable, only when (check late variances (which will only be valid for intrastate operations), and, with knowledge option Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (49 CFR 391.62) (Federal) Opriving within an exempt intracity zone (4

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hading the time for environing instructions, garbering the data needed, and completing and restraining the c	collection of information, All responses to this collection of informa Collection Charance Officer, Factoral Motor Carrier Safety Administ	Jon and mandatory. Send comments reperling this burden estimate at any asion, MC-883, 1200 News terrain Avenue, VC Washinston, D.C. 20593.	
Medical E	xaminer's Certificate	Property of the Company of the Compa	
	residence bedal collection		
try that I have examined Last Name: Bertson First Name	Curte 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, an	d, if applicable, only when (check all that apply) OR	
the Federal Motor Carrier Safety Regulations (49 CFR 191.41-391.49) with any applicable S	tare variances (which will only be valid for intrastate o	perations), and, with knowledge of the driving duties,	
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Wearing corrective lenses □ Accompanied by a	exemption Driving within an exempt SPD Certificate Qualified by operation of	intracity zone (49 CFR 191.62) Federall	
Cutoria and Control of the Control o	☐ Grandfathered from State	requirements (State)	
e information I have provided regarding this physical examination is true and complete. A	Complete Medical Examination Report Form,	Medical Exeminer's Certificate Expiration Date	
SA-5875, with any attachments embodies my findings completely and correctly, and is or	n file in my office.	12/16/2022	
elitgal Examinar's Signature	Medical Examiner's Telephone Number	Date Certificate Signed	
	(602)375-1155	12/16/2021	
adical Extendrun's Name (please print or type)		O Advanced Practice Nurse	
manual Rosale		O Other Practitioner (specify)	
edical Examiner's State License, Certificate, or Registration Number	leading State	National Registry Number	
1017	AZ	8249600872	
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775.	D10606542	AZ	
4 lad		CLPICOL Applicant/Holder	
ther's Address		The state of the s	
reet Address: 17600 N 79th Ave Chy: Gendale	State Province: AZ	Zip Code: 85308 ● Yes ○ No	
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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 1126-0006. Public reporting for this collection of Information is estimated to be approximately 25 minutes per response, including the time for reviewing Instructions, gathering the data needed, and completing and reviewing the collection of information are mandatory. Send comments regarding this burden or any other aspect of this collection of information, including suggestions for reducing this burden to:

						t us	MEDICAL REC	ORD#
SECTION 1. Driver Informa	ation (to be filled out by the	driver)			1	hard, files	(or stic	ker)
PERSONAL INFORMATION								e e
ast Name: Bentson	First Name:	Curtis	Mi	ddle Initial:	1:	Date of Birt	h: 04/16/1981	Age: 40
Street Address: 17600 N	79th Ave		City: Glendale	4 242-1	S	ate/Provin	ce: AZ Zip (ode: 853
Driver's License Number:	D10606542	Issuin	ng State/Province:	AZ	Phone:	(480)881	-1916	
-mail (optional):		0,5	CLP/CI	DL Applicant/Ho	lder*:	⊙Ye	s ONo	
			Driver	D Verified By**:	D	rivers Licen	se	9 (
Has your USDOT/FMCSA m	edical certificate ever been	denied or issu			a I to but a	Yes O No	O Not Sure	0 10
1P/CDL Applicant/Holder: See Instructions for definiti	ons.		The state of	** Driver ID Verified By: Recor	what type of pl	noto ID was used to ve	rify the identity of the driver, e.g.	, CDL, driver's acense, p.
- 1 Mar 201				** Driver ID Verified By: Recor	what type of pl	noto ID was used to ve	rify the identity of the driver, e.g	, CDL, driver's icense, p
DRIVER HEALTH HISTORY		plain below.		** Driver ID Verified By: Recor	what type of pl	oto ID was used to ve	Yes ⊙No	
DRIVER HEALTH HISTORY		plain below.		** Delver ID Verified By: Recor	what type of pl	note ID was used to re		
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PRIVER HEALTH HISTORY Have you ever had surgery Are you currently taking m	? If "yes", please list and exp		herbal remedies, d			note ID was used to ve)Not Sure
DRIVER HEALTH HISTORY Have you ever had surgery Are you currently taking m If "yes", please describe be Amlodipine Hydrochlothorizide	? If "yes", please list and exp		herbal remedies, d			note ID was used to ve	OYes ⊙No C)Not Sure

(Attach additional sheets if necessary)

Page 1

^{**}This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.**

DRIVER HEAL		First Name:	Cu	ırtis		DOB: 04/16/1981 Exam Date: 12/	/16/20)21	_
	TH HISTORY (continued)	· April ·			-			# ; # # (b)	न प्याप्त १ दश
Do vou have	or have your ever had:	Lorder Wins	Vas	No S	Not		Yes N	no consul	Not re
	n injuries or illnesses (e.g., cor	cussion)	0	0	O	16. Dizziness, headaches, numbness, tingling, or memory	0	0	0
2. Seizures, e			ŏ	o	Ö	loss		_	_
	ems (except glasses or contacts	:)	ō	0	Ö	17. Unexplained weight loss	0	0	0
	r hearing problems		0	0	0	18. Stroke, mini-stroke (TIA), paralysis, or weakness	0	0	0
	ase, heart attack, bypass, or o	ther heart	0	0	ŏ	19. Missing or limited use of arm, hand, finger, leg, foot, toe	_	0	0
problems	,	the near	O	O	0	20. Neck or back problems	0	0	0
6. Pacemake procedure	er, stents, implantable devices es	, or other heart	0	0	0	21. Bone, muscle, joint, or nerve problems 22. Blood clots or bleeding problems	0	0	0
7. High bloo	d pressure		0	0	0	23. Cancer	0	0	0
8. High chole	esterol		0	0	0	24. Chronic(long-term)infection or other chronic diseases	0	0	0
breathing	ong-term) cough, shortness o problems	f breath, or other	0	0	0	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	0	0	O
10. Lung dise	ase (e.g., asthma)		0	0	0	26. Have you ever had a sleep test (e.g., sleep apnea)?	0	0	C
11. Kidney pro urination	oblems, kidney stones, or pair	n/problems with	0	0	0	27. Have you ever spent a night in the hospital?	O	0	Ö
	liver, or digestive problems		0	0	0	28. Have you ever had a broken bone?	0	0	C
			0		0	29. Have you ever used or do you now use tobacco?	0	0	C
	or blood sugar problems		0	0	0	30. Do you currently drink alcohol?	Ö	o	Ö
Insulin u 14. Anxiety, d	lepression, nervousness, othe	er mental health	0	0	00	31. Have you used an illegal substance within the past two years?	0	0	C
problems 15. Fainting o	or passing out		0	0	0	32. Have you ever failed a drug test or been dependent on an illegal substance?	0	0	C
Other health	condition(s) not described a	bove:			27 "	OYes⊙No	ONG	t Su	re
Did you ansv		1-32? If so, please c	omm	ent fu	ırthei	r on those health conditions below. : ©Yes ONo	ONo	t Su	re
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Q7 - Hyper	, , , , , , , , , , , , , , , , , , , ,	Since Since	2	ASI		M. Marty System			
And the Paris		W-		A	\ \frac{1}{2}	(Attach additional sheets if nec	essary)	10
CMV DRIVER	ts SIGNATURE the above information is accurate Examiner's Certificate, that or intentionally false information	t submission of frau	udulei	nt or	inten	(Attach additional sheets if necessary of the control of the contr	exan	ninat	issic
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TESTING .	\$ 1.75 to 3 sections	, , , , , , , , , , , , , , , , , , ,					1. [1.]	- Art Ett - EX	
	88							B .1	
Pulse rate:	P	Pulse rhythm regu	ılar: • Yes	O No	Height: 5 feet 1	_inches Weigl	ht: 179 pou	ınds	
Blood Pres	ssure Systoli	c	Diastolic		Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting	136		94		Urinalysis is require	d. 1.015	Negative	Negative	Negative
Second read (optional)	ding 134	and other land	86		Numerical reading must be recorded.	s			
Other testing	g if indicated	Carrier P	S Kauseral — Naziragiani (l houves	Protein, blood, or sug rule out any underlyi	par in the urine ma ng medical proble	ny be an indica em.	tion for further	testing to
Vision Standard is at I least 70° field o rective Ienses si	least 20/40 acuity (Si f vision in hortzonta hould be noted on ti	neilen) in each eye I meridian measur he Medical Examin	with or without co ed in each eye. Th er's Certificate.	orrection. At e use of cor-		or equal to 40 dB,	in better ear (v	vith or without	average thearing aid).
Acuity	Uncorrected	Corrected H	orizontal Field o	Vision	Check if hearing aid u Whisper Test Results		Rigit Car 🔲	Right Ear	_
Right Eye:	20/ 30	20/ Ri	ght Eye: 85	degrees	Record distance (in fee		which a forc		
Left Eye:	20/ 40	20/ Le	eft Eve: 85	degrees	whispered voice can f	irst be heard		5	_ 5
Both Eyes:	20/ 30	20/		Yes No	Audiometric Test Re	rulte			
signals and d Monocular vi	n recognize and di devices showing re ision	istinguish among ed, green, and am	traffic control ber colors	0 0	Right Ear 500 Hz 1000 Hz	2000 Hz	Left Ear 500 Hz	1000 Hz	2000 Hz
	1.1 1 1 1.			~ ~			_		
	ophthalmologist or cumentation from	•	t or optometrist?	0 0	Average (right):		Average (le	eft):	
Received doc	cumentation from	ophthalmologis		0 0					
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Last Name: Bentson First Name:	Curtis	DOB:	04/16/1981		Exam Date:	12/16	/2021
Please complete only one of the following (Federal or State) Med	iical Examiner	Determination s	ections:				
MEDICAL EXAMINER DETERMINATION (Federal)							
Use this section for examinations performed in accordance with the	Federal Motor C	arrier Safety Regu	lations (49 C	FR 391,41	1-391.49):		
O Does not meet standards (specify reason);			· !		-		
O Meets standards in 49 CFR 391.41; qualifies for 2-year certification	te				1 41		
Meets standards, but periodic monitoring required (specify rec	ison):	ntn					
0		other (specify):					
		a walver/exemp			64 (Endoral)		
Accompanied by a Skill Performance Evaluation (SPE) Certifica		Qualified by op	eration of <u>49</u>	CFK 391	1.04 (Federal)		
Driving within an exempt intracity zone (see 49 CFR 391.62) (Fe	aerai)						
Determination pending (specify reason):		and the same of					
☐ 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:		1 .	_	
Incomplete examination (specify reason):		Control Control					
If the driver meets the standards outlined in 49 CFR 391.41, the	en complete a Me	dical Examiner's C	Certificate as:	stated in	49 CFR 391.43(h), as ap	propriate.
I have performed this evaluation for certification. I have personally	y reviewed all a	vallable records	and recorde	d inform	ation pertainin	g to th	is evaluation,
and attest that, to the best of my knowledge, I believe it to be true	e and correct.						
Medical Examiner's Signature: Medical Examiner's Name (please print or type): Banasiak	Rosalle		1 10				
Medical Examiner's Name (please print or type): Banasiak	City: Ph	oenix	1.11	– State:	AZ Zip	Code:	85029-1346
Medical Examiner's Telephone Number: (602)375-1155		rtificate Signed:	12/16/		1.11		
Medical Examiner's State License, Certificate, or Registration Num	775-9	5037			Issuing	State:	AZ
MD DO Physician Assistant Chiropractor	_			-			
Other Practitioner (specify):							
National Registry Number: 8249600872	Medi	cal Examiner's Ce	ertificate Exp	iration [Date: <u>12</u>	/16/20	22