Form MCSA-5876

Taylor, Shabu
MRN: 104882071 DOB: 6/7/1971
Age/Gender: 50 y.o./male
VT: Well Physical 11/08/21
Jason Torrente, DO RUCCWIL BCBS
HORIZON PPO

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 requi 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 estim including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send co 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
Safety Administration

Medical Examiner's Certificate
(for Commercial Driver Medical Certification)

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

- [x] 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)*:
  - [x] 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: 11/8/2023

Medical Examiner's Signature

Medical Examiner's Telephone Number: 6098712045

Date Certificate Signed: 11/8/2021

Medical Examiner's Name *(please print or type)*: JASON TORRENTE D.O.

- [ ] MD
- [ ] Physician Assistant
- [ ] Advanced Practice Nurse
- [x] DO
- [ ] Chiropractor
- [ ] Other Practitioner *(specify)* _____

Medical Examiner's State License, Certificate, or Registration Number: 25MB07308300

Issuing State: New Jersey

National Registry Number: 4342890983

Driver's Signature

Driver's License Number: T09470372066712

Issuing State/Province: N.J.

Driver's Address

Street Address: 21 Boxwood Ln City: Willingboro State/Province: N.J. Zip Code: 08046

CLP/CDL Applicant/Holder
- [x] Yes
- [ ] No

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