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APPLICATION FOR EMPLOYMENT

COMPANY [illegible] STREET ADDRESS [illegible]

CITY, STATE AND ZIP CODE [illegible]

NAME Tracy Lee Ziegler
(First) (Middle) (Maiden Name, if any) (Last)

ADDRESS 6519 W. Holiday St. Homosassa, FL 34446 HOW LONG? 20yr.
(Street) (City)

DATE OF BIRTH 10-5-1973 SOCIAL SEC. NO. 329-62-0673

ADDRESS none HOW LONG? _____
(Street) (City) (State and Zip Code)

FOR PAST THREE YEARS

(Street) none HOW LONG? _____
(City) (State and Zip Code)

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS—DRIVER

	STATE	LICENSE NO.	TYPE	EXPIRATION DATE
DRIVER	FL	Z246817733650	A	10-5-22
LICENSES				

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE BODY (VAN, TANK, FLAT, ETC.)	FROM	TO	APPROX. NO. OF MILES (Optional)
STRAIGHT TRUCK	I Been driving		Since	2001
TRACTOR—ONE TRAILER				
TRACTOR—TWO TRAILERS	grown	up on	farm	
OTHER				

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

	DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES
LAST ACCIDENT	June 3 2018	Hit by Ruck Truck	no	no
NEXT PREVIOUS	Was not on my DOT as just crash	Ticketed not at fault		

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

LOCATION	DATE	CHARGE	PENALTY
Marion County, TX	6-7-2016	Red light	Camera

(ATTACH SHEET IF MORE SPACE IS NEEDED)

a. [illegible] YES ______ NO ✓

b. Has any license, permit or privilege ever been suspended or revoked? YES ______ NO ✓

IF THE ANSWER TO EITHER A OR B IS YES, ATTACH STATEMENT GIVING DETAILS

EMPLOYMENT HISTORY (Attach Sheet If More Space Is Needed)

NOTE: DOT Requires That Employment for at Least 3 Years and/or Commercial Driving Experience for the Past 10 Years Be Shown

LAST EMPLOYER: NAME ______

ADDRESS ______

POSITION HELD ______ FROM ______ TO ______ SALARY ______

REASONS FOR LEAVING ______

SECOND LAST EMPLOYER: NAME ______

ADDRESS ______

POSITION HELD ______ FROM ______ TO ______ SALARY ______

REASONS FOR LEAVING ______

THIRD LAST EMPLOYER: NAME ______

ADDRESS ______

POSITION HELD ______ FROM ______ TO ______ SALARY ______

REASONS FOR LEAVING ______

TO BE READ AND SIGNED BY APPLICANT

[illegible]

6-8-2021 — Date

[signature] — Applicant's Signature

[illegible]

EMPLOYMENT HISTORY

All driver applicants to drive in interstate commerce must provide the following information on all employers during the preceding three years. List complete mailing address, street number, city, state, and zip code.

Applicants to drive a commercial motor vehicle* in intrastate or interstate commerce shall also provide an additional seven years information on those employers for whom the applicant operated such vehicle.

(NOTE: List employers in reverse order starting with the most recent. Add another sheet as necessary.)

EMPLOYER	DATE
NAME: Bard Transport	FROM MO. 2 YR. 21 TO MO. 6 YR. 21
ADDRESS: 4445 Forest ave	POSITION HELD: Driver
CITY: Brookfield STATE: IL ZIP: 6513	SALARY/WAGE: .68
CONTACT PERSON: Saftey PHONE #: ( )	REASON FOR LEAVING: Re Fertior pay
EMPLOYER	**DATE**
NAME: MTC Friegnt	FROM MO. [illegible] YR. 2019 TO MO. Dec YR. 20
ADDRESS: 11773 8th ave	POSITION HELD: Driver
CITY: Saint Petersburg STATE: FL ZIP:	SALARY/WAGE: .60
CONTACT PERSON: Saftey PHONE #: (727) 2029293	REASON FOR LEAVING: Driver
EMPLOYER	**DATE**
NAME: South Trans	FROM MO. Feb YR. 19 TO MO. May YR. [illegible]
ADDRESS: 1453 embassy clr.	POSITION HELD:
CITY: Clearwater STATE: FL ZIP:	SALARY/WAGE: could not speak
CONTACT PERSON: Saftey PHONE #: ( )	REASON FOR LEAVING: engilsh
EMPLOYER	**DATE**
NAME: Ziegler World Wide	FROM MO. Dec YR. 20[illegible] TO MO. Feb YR. 299
ADDRESS: 6519 W. Holiday St.	POSITION HELD: my own
CITY: Homosassa STATE: FL ZIP: 34446	SALARY/WAGE: Authorite
CONTACT PERSON: PHONE #: (352) 601-6047	REASON FOR LEAVING: Closed Buiss
EMPLOYER	**DATE**
NAME:	FROM MO. YR. TO MO. YR.
ADDRESS:	POSITION HELD:
CITY: STATE: ZIP:	SALARY/WAGE:
CONTACT PERSON: PHONE #: ( )	REASON FOR LEAVING:
EMPLOYER	**DATE**
NAME:	FROM MO. YR. TO MO. YR.
ADDRESS:	POSITION HELD:
CITY: STATE: ZIP:	SALARY/WAGE:
CONTACT PERSON: PHONE #: ( )	REASON FOR LEAVING:

* Includes vehicles having a GVWR of 26,001 lbs. Or more, vehicles designed to transport 15 or more passengers, or any size vehicle used to transport hazardous materials in a quantity requiring placarding.

USE THIS SHEET FOR ADDITIONAL EMPLOYMENT HISTORY INFORMATION
(NOTE: LIST EMPLOYERS IN REVERSE ORDER STARTING WITH THE MOST RECENT)

[illegible] the following information on all employers during the preceding 3 years. List complete mailing address: street number, city, state and zip code.

Applicants to drive a commercial motor vehicle in intrastate or interstate commerce shall also provide an additional 7 years' information on those employers for whom the applicant operated such vehicle.

(NOTE: List employers in reverse order starting with the most recent.)

EMPLOYER | DATE

NAME IMSC Express Transport — 15 – 12 – 15
ADDRESS — Driver
CITY [illegible] STATE [illegible] ZIP — 42 ¢ mile
CONTACT PERSON Lynn PHONE NUMBER 352-874-4147 Yes Truck Accident
[illegible]
WAS YOUR JOB DESIGNATED AS A SAFETY SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF [illegible]

EMPLOYER | DATE

NAME Peterson Trucking — 15 – 9 – 15
ADDRESS 3560 SW 1st Ave — Driver
CITY Gainesville STATE Fl ZIP 32607 — 40 ¢ mile
CONTACT PERSON Mr. Peterson PHONE NUMBER 205-245-4274 Accident
[illegible]
WAS YOUR JOB DESIGNATED AS A SAFETY SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF [illegible]

EMPLOYER | DATE

NAME IMSC Express Transport — 13 – 13 – 15
ADDRESS — Driver
CITY Ocala STATE Fl ZIP — 42 ¢ mile
CONTACT PERSON Lynn [illegible]
[illegible]
WAS YOUR JOB DESIGNATED AS A SAFETY SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF [illegible]

EMPLOYER | DATE

NAME Reed Trans — 13 – 12 – 13
ADDRESS P.O. Box [illegible] — Driver
CITY Cedar Grove STATE WI ZIP 53013 — 39 ¢ mile
CONTACT PERSON [illegible]
WERE YOU SUBJECT TO THE FMCSRs WHILE EMPLOYED [illegible]
WAS YOUR JOB DESIGNATED AS A SAFETY SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF [illegible]

EMPLOYER | DATE

NAME [illegible]
ADDRESS 2244 [illegible] Dr — Driver
CITY Leesburg STATE Fl ZIP 34748 — 32 ¢ mile
[illegible]
WERE YOU SUBJECT TO THE FMCSRs WHILE EMPLOYED [illegible]
WAS YOUR JOB DESIGNATED AS A SAFETY SENSITIVE FUNCTION [illegible]

EMPLOYMENT HISTORY (continued)

EMPLOYER | DATE

NAME ABCO Transport | FROM MO 12 YR 12 TO MO 7 YR 13

ADDRESS | Driver

CITY Dade City | STATE FL | ZIP | SALARY/WAGE 38 ¢ mile

CONTACT PERSON Safety | PHONE NUMBER | REASON FOR LEAVING Lookin for Something

WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? ✓YES __ NO

WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? ✓YES __ NO

EMPLOYER | DATE

NAME Wilson & Company | FROM MO 4 YR 12 TO MO 11 YR 12

ADDRESS 4230 Pine Bend Trail | Driver

CITY Rosemount | STATE MN | SALARY/WAGE 37 ¢ mile

CONTACT PERSON | PHONE NUMBER | REASON FOR LEAVING Did not Pay

WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? ✓YES __ NO

WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? ✓YES __ NO

EMPLOYER | DATE

NAME Lessors, Inc. | FROM MO 8 YR 11 TO MO 4 YR 12

ADDRESS 1056 Gemini Rd | Driver

CITY Eagan | STATE MN | ZIP 55121 | SALARY/WAGE

CONTACT PERSON Safety | PHONE NUMBER 651-454-1202 | REASON FOR LEAVING No miles

WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? ✓YES __ NO

WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? ✓YES __ NO

EMPLOYER | DATE

NAME Sunco Transport | FROM MO 4 YR 11 TO MO 8 YR 11

ADDRESS 1025 [illegible] | Driver

CITY Lakeland | STATE FL | ZIP 33805 | SALARY/WAGE

CONTACT PERSON Safety | PHONE NUMBER 1-800-231-9288 | REASON FOR LEAVING No money

WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? [illegible]

WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? [illegible]

EMPLOYER | DATE

NAME Marten Transport | FROM MO 6 YR 10 TO MO 4 YR 11

ADDRESS 129 Marten St | Driver

CITY Mondovi | STATE WI | ZIP 54755 | SALARY/WAGE 37 ¢ mile

CONTACT PERSON | PHONE NUMBER 1-800-395-3000 | REASON FOR LEAVING No miles

WERE YOU SUBJECT TO THE FMCSRs* WHILE EMPLOYED? [illegible]

WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? [illegible]

*Includes vehicles having a GVWR of [illegible] ... designed to transport 16 or more passengers, including the driver, or any size vehicle used to transport hazardous materials [illegible]

**The Federal Motor Carrier Safety Regulations (FMCSRs) apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: (1) weighs or has a GVWR of 10,001 pounds or more, (2) is designed or used to transport more than 8 passengers (including the driver), OR (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

EMPLOYMENT HISTORY (continued)

EMPLOYER	DATE
NAME Walton & Company	FROM mo 2 yr 9 TO mo 6 yr 10
ADDRESS 1201 Tom Bond Cir.	POSITION Driver
CITY Rosemont STATE MN ZIP	SALARY/WAGE 34 $/mile
SUPERVISOR'S NAME Safety	PHONE NUMBER 651-324-2097 REASON FOR LEAVING Laid Off
WERE YOU SUBJECT TO THE FMCSR'S WHILE EMPLOYED?	
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40?	

EMPLOYER	DATE
NAME Ziegler's Lawn & Landscaping	FROM mo 6 yr 7 TO mo 2 yr 9
ADDRESS 3614 S. Victoria Dr	POSITION Laborer/Driver
CITY Homosassa STATE FL ZIP 34448	SALARY/WAGE $ 520 Weekly
CONTACT PERSON Mike or Cindy PHONE NUMBER 352-382-1944	REASON FOR LEAVING Business Closed
WERE YOU SUBJECT TO THE FMCSR'S WHILE EMPLOYED?	
WAS YOUR JOB DESIGNATED AS A SAFETY SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40?	

EMPLOYER	DATE
NAME Dicks Moving	FROM mo 9 yr 6 TO mo 1 yr 7
ADDRESS 2231 S. Ivy Dr.	POSITION Driver
CITY Homosassa STATE FL ZIP 34448	SALARY/WAGE $ per Mile
CONTACT PERSON Safety PHONE NUMBER 352-628-1260	REASON FOR LEAVING Laid Off
WERE YOU SUBJECT TO THE FMCSR'S WHILE EMPLOYED?	
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40?	

EMPLOYER	DATE
NAME Arnold & Sons	FROM mo 9 yr 5 TO mo 5 yr 06
ADDRESS 5630 W. Grover Cleveland	POSITION Driver
CITY Homosassa STATE FL ZIP 34446	SALARY/WAGE $ per mile
CONTACT PERSON Dale PHONE NUMBER 352-436-3430	REASON FOR LEAVING 352-586-3048 Closed Business
WERE YOU SUBJECT TO THE FMCSR'S WHILE EMPLOYED?	
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40?	

EMPLOYER	DATE
NAME	FROM TO
ADDRESS	POSITION
CITY	SALARY/WAGE
CONTACT PERSON	PHONE NUMBER
WERE YOU SUBJECT TO THE FMCSR'S WHILE EMPLOYED? YES NO	REASON FOR LEAVING
WAS YOUR JOB DESIGNATED AS A SAFETY-SENSITIVE FUNCTION IN ANY DOT-REGULATED MODE SUBJECT TO THE DRUG AND ALCOHOL TESTING REQUIREMENTS OF 49 CFR PART 40? YES NO	

*Includes vehicles having a GVWR of 26,001 lbs. or more, vehicles designed to transport 16 or more passengers (including the driver), or any size vehicle used to transport hazardous materials in a quantity requiring placarding.

**The Federal Motor Carrier Safety Regulations (FMCSRs) apply to anyone operating a motor vehicle on a highway in interstate commerce to transport passengers or property when the vehicle: (1) Has a GVWR of 10,001 pounds or more; (2) is designed or used to transport more than 8 passengers (including the driver); or (3) is of any size and is used to transport hazardous materials in a quantity requiring placarding.

Form MCSA-5875

OMB No. 2126-0006 Expiration Date:

U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECOR

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)

PERSONAL INFORMATION

Last Name: Ziegler First Name: Tracy Middle Initial: L Date of Birth: 10/05/1973 A

Street Address: 6519 W. Holliday St City: Homosassa State/Province: FL Zip Code: 34

Driver's License Number: Z245-812-73-365-0 Issuing State/Province: FL Phone: (352) 601-6027 Gender: ◉ M

E-mail (optional): zieglertracy93@yahoo.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 definition.

**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,

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below. ◉ Yes ○ No ○ Not

Left knee injury

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below. ◉ Yes ○ No ○ Not S

Metformin (unsure of dosage) BID

(Attach additional sheets if necessary)

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

Last Name: Ziegler First Name: Tracy DOB: 10/05/1973 Exam Date: 11/05/2020

DRIVER HEALTH HISTORY (continued)

Do you have or have you ever had:	Yes	No	Not Sure
1. Head/brain injuries or illnesses (e.g., concussion)	○	◉	○
2. Seizures, epilepsy	○	◉	○
3. Eye problems (except glasses or contacts)	○	◉	○
4. Ear and/or hearing problems	○	◉	○
5. Heart disease, heart attack, bypass, or other heart problems	○	◉	○
6. Pacemaker, stents, implantable devices, or other heart procedures	○	◉	○
7. High blood pressure	○	◉	○
8. High cholesterol	○	◉	○
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	○	◉	○
10. Lung disease (e.g., asthma)	○	◉	○
11. Kidney problems, kidney stones, or pain/problems with urination	○	◉	○
12. Stomach, liver, or digestive problems	○	◉	○
13. Diabetes or blood sugar problems	◉	○	○
Insulin used	○	◉	○
14. Anxiety, depression, nervousness, other mental health problems	○	◉	○
15. Fainting or passing out	○	◉	○
16. Dizziness, headaches, numbness, tingling, or memory loss	○	◉	○
17. Unexplained weight loss	○	◉	○
18. Stroke, mini-stroke (TIA), paralysis, or weakness	○	◉	○
19. Missing or limited use of arm, hand, finger, leg, foot, toe	○	◉	○
20. Neck or back problems	○	◉	○
21. Bone, muscle, joint, or nerve problems	○	◉	○
22. Blood clots or bleeding problems	○	◉	○
23. Cancer	○	◉	○
24. Chronic (long-term) infection or other chronic diseases	○	◉	○
25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	○	◉	○
26. Have you ever had a sleep test (e.g., sleep apnea)?	○	◉	○
27. Have you ever spent a night in the hospital?	○	◉	○
28. Have you ever had a broken bone?	○	◉	○
29. Have you ever used or do you now use tobacco?	◉	○	○
30. Do you currently drink alcohol?	○	◉	○
31. Have you used an illegal substance within the past two years?	○	◉	○
32. Have you ever failed a drug test or been dependent on an illegal substance?	○	◉	○

Other health condition(s) not described above: ○ Yes ◉ No ○ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below. ◉ Yes ○ No ○ Not Sure

13. Takes medication as prescribed
29. Smokes about 1 pack of cigarettes a per day

(Attach additional sheets if necessary)

CMV DRIVER'S SIGNATURE

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: _____ Date: _____

SECTION 2. Examination Report (to be filled out by the medical examiner)

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

Left patellar fracture in childhood. No residual symptoms.
Takes medication as prescribed.

(Attach additional sheets if necessary)

Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Ziegler First Name: Tracy DOB: 10/05/1973 Exam Date: 11/05/2020

TESTING

Pulse rate: 68 Pulse rhythm regular: (•) Yes ( ) No Height: 5 feet 8 inches Weight: 234 pounds

Blood Pressure	Systolic	Diastolic
Sitting	132	80
Second reading (optional)		

Other testing if indicated

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.010	Neg	Neg	2000+

Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity:	Uncorrected	Corrected
Right Eye:	20/15	20/
Left Eye:	20/20	20/
Both Eyes:	20/20	20/

Horizontal Field of Vision: Right Eye: 90 degrees Left Eye: 90 degrees

	Yes	No
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors.	(•)	( )
Monocular vision		
Referred to ophthalmologist or optometrist?	( )	(•)
Received documentation from ophthalmologist or optometrist?	( )	(•)

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☒ Neither

Whisper Test Results

Record distance (in feet) from driver at which a forced whispered voice can first be heard

Right Ear	Left Ear
5	5

OR

Audiometric Test Results

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz

Average (right): Average (left):

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal
1. General	(•)	( )
2. Skin	(•)	( )
3. Eyes	(•)	( )
4. Ears	(•)	( )
5. Mouth/throat	(•)	( )
6. Cardiovascular	(•)	( )
7. Lungs/chest	(•)	( )
8. Abdomen	(•)	( )
9. Genito-urinary system including hernias	( )	(•)
10. Back/Spine	(•)	( )
11. Extremities/joints	(•)	( )
12. Neurological system including reflexes	(•)	( )
13. Gait	(•)	( )
14. Vestibular system	(•)	( )

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

Request PCP documentation and clearance that NIDDM is being monitored and controlled due to physician.
Recommend cessation.
Recommend continued diet and exercise.

(Attach additional sheets if necessary)

Form MCSA-5875

OMB No. 2126-0006 Expiration Date: 11/30/2021

Last Name: Ziegler First Name: Tracy DOB: 10/05/1973 Exam Date: 11/05/2020

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

MEDICAL EXAMINER'S DETERMINATION (Federal)

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- ○ Does not meet standards *(specify reason)*:
- ○ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ◉ Meets standards, but periodic monitoring required *(specify reason)*: NIDDM

Driver qualified for: ○ *3 months* ○ *6 months* ✓ *1 year* ○ *other (specify)*:

- ☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption *(specify type)*:
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)
- ☐ Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- ☒ Determination pending (specify reason): Documentation of glucose monitoring.
  - ☒ Return to medical exam office for follow-up on (must be 45 days or less): 11/30/2020
  - ☑ Medical Examination Report amended *(specify reason)*:
  - *(If amended)* Medical Examiner's Signature: Date:
- ☐ Incomplete examination *(specify reason)*:

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge I believe it to be true and correct:

Medical Examiner's Signature:

Medical Examiner's Name *(please print or type)*: Geneva Stephens

Medical Examiner's Address: 2649 W. Silver Springs Blvd City: Ocala State: FL Zip Code: 34475

Medical Examiner's Telephone Number: (352)789-6777 Date Certificate Signed: 11/05/2020

Medical Examiner's State License, Certificate, or Registration Number: CH9861 Issuing State: FL

☐ MD ☐ DO ☐ Physician Assistant ☒ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner *(specify)*:

National Registry Number: 9456701840 Medical Examiner's Certificate Expiration Date: 11/5/2021

Form MCSA-5876

OMB No. 2126-0006 Expiration Date: [illegible]

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 of information is estimated to be [illegible] [illegible] 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:** Ziegler **First Name:** Traci [illegible] in accordance with 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 [illegible]

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 [illegible] **OR**

- ☐ 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) [illegible]
- ☐ Qualified by operation of 49 CFR 391.64 [illegible]
- ☐ 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: 11/5/2021

Medical Examiner's Signature: [signature]

Medical Examiner's Telephone Number: 3527891677

Date Certificate Signed: 11/5/2020

Medical Examiner's Name *(please print or type)*: Geneva Stephens

☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse
☐ DO ☒ Chiropractor ☐ Doctor of Chiropractic [illegible]

Medical Examiner's State License, Certificate, or Registration Number: CH9861

Issuing State: FL

National Registry Number: 9456701840

Driver's Signature: [signature]

Driver's License Number: Z246812733650

Issuing State/Province: FL

Driver's Address

Street Address: 6519 W Holiday St Homosassa **City, State/Province:** FL **Zip Code:** 34446

CLP/CDL Applicant/Holder ☑ Yes ☐ No

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