

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 the 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 one minute per response, 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 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-BRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

OMB No: 2126-0006 Expiration Date: 03/31/2024

### Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: MILLAN First Name: DEYAN SOSA 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 ☐ 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 Signature: Sheila Shepherd Medical Examiner's Telephone Number: 432 689 1818 Date Certificate Signed: 4/3/24

Medical Examiner's Name (please print or type): Sheila Shepherd

Medical Examiner's State License, Certificate, or Registration Number: 1603130 Issuing State: TX National Registry Number: 1006453140

Driver's Signature: \_\_\_\_\_ Driver's License Number: 11845941 Issuing State/Province: TX

Driver's Address: 1014 Emerson Rd City: Barstow State/Province: TX Zip Code: 77079 CLP/CDL Applicant/Holder: ☒ Yes ☐ No

\*\*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.\*\*

Rev 3/1/24



## 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 approximately 25 minutes per response, 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 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-PRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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: Millan First Name: Joe Ray Middle Initial: S Date of Birth: 7-24-71 Age: 53  
Street Address: 101 Clemens Rd. City: Barstow State/Province: TX Zip Code: 79719  
Driver's License Number: 11875941 Issuing State/Province: TX Phone: 432/391/9706  
E-Mail (optional): joeraymillan443@gmail.com CLP/CDL Applicant/Holder\*: ☒ Yes ☐ No  
Driver ID Verified By\*\*: CDL AS  
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 Sure

yes ~~1987~~ 1987, 1988, 1994, 1996 for Knee fusion

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)?  
If "yes," please describe below.

☒ Yes ☐ No ☐ Not Sure

High blood pressure - unsure of name

(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 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: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**DRIVER HEALTH HISTORY (continued)**

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

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

(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: 4-3-24**SECTION 2. Examination Report (to be filled out by the medical examiner)****DRIVER HEALTH HISTORY REVIEW**

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).

(Attach additional sheets if necessary)



Last Name: milan First Name: JOE RAY SUSA DOB: 7-24-71 Exam Date: 8-3-24

**TESTING**

Pulse Rate: 91 Pulse rhythm regular: ☒ Yes ☐ No

Height: 5 feet 10 inches Weight: 204 pounds

Blood Pressure Systolic Diastolic

Sitting 145 90

Second reading  
(optional)

Other testing if indicated

Urinalysis Sp. Gr. Protein Blood Sugar

Urinalysis is required.  
Numerical readings  
must be recorded.

1.030 neg neg neg

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 Horizontal Field of Vision  
Right Eye: 20/ 75 20/      Right Eye: 75 degrees  
Left Eye: 20/ 75 20/      Left Eye: 75 degrees  
Both Eyes: 20/ 75 20/     

Yes No

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors ☒ Yes ☐ No

Monocular vision ☐ Yes ☒ No

Referred to ophthalmologist or optometrist? ☐ Yes ☒ No

Received documentation from ophthalmologist or optometrist? ☐ Yes ☒ No

**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 5 ft Left Ear 5 ft

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**

1. General

2. Skin

3. Eyes

4. Ears

5. Mouth/throat

6. Cardiovascular

7. Lungs/chest

Normal Abnormal

☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐

**Body System**

8. Abdomen

9. Genito-urinary system including hernias

10. Back/spine

11. Extremities/joints

12. Neurological system including reflexes

13. Gait

14. Vascular system

Normal Abnormal

☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐  
☒ ☐

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.

⑪ Fusion of knee

(Attach additional sheets if necessary)



Last Name: MILLON First Name: JOERAY SOSA DOB: 7-24-71 Exam Date: 4-3-24

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

**MEDICAL EXAMINER 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): HN
- 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
- ☐ Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- ☐ Determination pending (specify reason): \_\_\_\_\_
- ☐ 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: \_\_\_\_\_
- ☐ 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: Sheila Sheperd

Medical Examiner's Name (please print or type): Sheila Sheperd

Medical Examiner's Address: 4506 Briarwood City: Midland State: TX ☒ Zip Code: 79707

Medical Examiner's Telephone Number: (432) 689-6818 Date Certificate Signed: 4/3/24

Medical Examiner's State License, Certificate, or Registration Number: 1003130 Issuing State: TX ☒

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

☐ Other Practitioner (specify): \_\_\_\_\_

National Registry Number: 1006453140

Medical Examiner's Certificate Expiration Date: 4/3/25