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

Medical Examiner's Certificate

(to Commercial Driver Medical Certification)

I certify that I have examined **Last Name:** Cadwell **First Name:** Bryan 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
- [ ] 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
02/28/2025

Medical Examiner's Signature [signature], PA-C

Medical Examiner's Telephone Number 912-537-9488

Date Certificate Signed 2/29/24

Medical Examiner's Name *(please print or type)* Daniel Dasher PA-C

( ) MD (●) Physician Assistant ( ) Advanced Practice Nurse
( ) DO ( ) Chiropractor ( ) Other Practitioner (specify) _____

Medical Examiner's State License, Certificate, or Registration Number 8752

Issuing State GA

National Registry Number 6650100135

Driver's Signature [signature]

Driver's License Number 052HH5185

Issuing State/Province GA

Driver's Address
Street Address: 199 Horseshoe Rd **City:** Glenwood **State/Province:** GA **Zip Code:** 30428

CLP/CDL Applicant/Ho
( ) 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 inadvert 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."

Re

Form MCSA-5875

Last Name: Cadwell First Name: Bryan DOB: 01 | 11 | 1990 Exam Date: 2/29/24

OMB No.: 2126-0006 Expiration Date: 03/31/2025

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)*: HTN
  - 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)*: _____
  - ☐ 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: DPD PA-C

Medical Examiner's Name *(please print or type)*: Daniel Dasher PA-C

Medical Examiner's Address: 1608 Meadows Lane City: Vidalia State: GA Zip Code: 30474

Medical Examiner's Telephone Number: 912-537-9488 Date Certificate Signed: 2/29/24

Medical Examiner's State License, Certificate, or Registration Number: 8752 Issuing State: GA

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

☐ Other Practitioner *(specify)*: _____

National Registry Number: 6650100135

Medical Examiner's Certificate Expiration Date: 02/28/2025

OMB No.: 2126-0006 Expiration Date: 03/31/2025

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: Caldwell First Name: Bryan Middle Initial: E Date of Birth: 01/11/1990 Age: 32

Street Address: 199 Horseshoe road City: Glenwood State/Province: Ga Zip Code: 30428

Driver's License Number: 052445185 Issuing State/Province: Ga Phone: 7124232389

E-Mail (optional): Probatcanes@gmx.com

CLP/CDL Applicant/Holder*: ☑ Yes ☐ No

Driver ID Verified By**: GA CDL BB

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

e you currently taking medications *(prescription, over-the-counter, herbal remedies, diet supplements)*? ● Yes ☒ No ☐ Not Sure
es," please describe below.

Hydrochlorothiazide 25mg
Benazepril 20 mg

(Attach additional sheets if necessary)

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ion appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when
r required to be maintained by regulatory requirements.**

2022

Form MCSA-5875 OMB No.: 2126-0006 Expiration Date: 03/31/2025

Last Name: Cudworth First Name: Bryan DOB: 01/11/90 Exam Date: 7/21/22

TESTING

Pulse Rate: 107 Pulse rhythm regular: (●) Yes ( ) No

Height: 6' feet ___ inches Weight: 176 pounds

Blood Pressure

	Systolic	Diastolic
Sitting	136	82
Second reading *(optional)*		

Other testing if indicated

N/A

Urinalysis

	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.020	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:	20/20	20/___	Right Eye: 80 degrees
Left Eye:	20/20	20/___	Left Eye: 80 degrees
Both Eyes:	20/20	20/___	

	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
5ft	5ft

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. Vascular 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.

N/A

(Attach additional sheets if necessary)

Form MCSA-5875

OMB No.: 2126-0006 Expiration Date:

Last Name: Cadwell First Name: Bryan Exam Date: 02/27/24

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 (e.g., asthma)			
10. Lung disease			
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 problems			
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. Back 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?			

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

On medication

(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: Bryan D. Cadwell Date: 02/27/2024

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 operation of a commercial motor vehicle (CMV).

HTN well controlled w/o side effects.

Public Burden Statement
A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently 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, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. All responses to this information collection are mandatory. Send comments regarding the accuracy of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue SE, Washington, DC 20590.

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

OMB No.: 2126-0006

Medical Examination Report Form
(for Driver Certification)

MEDICAL RECORD #

(or sticker)

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

PERSONAL INFORMATION

Last Name: Cadwell First Name: Bryan Middle Initial: B Date of Birth: 01/11/90 Age: 34

Street Address: 199 Horseshoe road City: Glenwood State/Province: Ga Zip Code: 30428

Driver's License Number: 052445185 Issuing State/Province: Ga Phone: 7124232581

Email (optional): ProOutcomes@gmx.com

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.

CLP/CDL Applicant/Holder*: ✓ Yes ○ No

Driver ID Verified By**: DL GA P.O.

**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

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

Benazepril
HcT2

(Attach additional sheets if necessary)

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