Form MCSA-5876 OMB No.: 2126-0006 Expiration Date: 03/31/2025

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 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-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:** ROBINSON **First Name:** REGINALD 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)*:

[x] 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 [ ] 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
09/28/2023

Medical Examiner's Signature [signature]

Medical Examiner's Telephone Number (847) 378-8147

Date Certificate Signed 09/28/2022

Medical Examiner's Name *(please print or type)* BRIAN KILKUS

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

Medical Examiner's State License, Certificate, or Registration Number 038.012584

Issuing State IL

National Registry Number 1410813531

Driver's Signature [signature]

Driver's License Number 12837431

Issuing State/Province TX

Driver's Address
Street Address: 2503 PANAGARD DR. APT 1304 City: HOUSTON State/Province: TX Zip Code: 77082

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.

13220928478124 **YOU MUST PROVIDE YOUR STATE DRIVER LICENSING AGENCY WITH THE COPY OF THE MEDICAL CERTIFICATE. MED-STOP DOES NOT SEND IT TO THE SDLA.** Rev 3/29/22

Form MCSA-5876 OMB No. 2126-0006 Expiration Date: 03/31/2025

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

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

13220928478124

CMV DRIVER CERTIFICATION

I certify that I have examined Last Name: ROBINSON First Name: REGINALD 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: 9/28/2023

MEDICAL EXAMINER INFORMATION

Medical Examiner's Signature: [signature]

Medical Examiner's Telephone Number: (847) 378-8147

Date Certificate Signed: 9/28/2022

Medical Examiner's Name (please print or type): BRIAN KILKUS

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

Medical Examiner's State License, Certificate, or Registration Number: 038.012584

Issuing State: IL

National Registry Number: 1410813531

CMV DRIVER INFORMATION

Driver's Signature: [signature]

Driver's License Number: 12837431

Issuing State/Province: TX

Driver's Address

Street Address: 2503 PANAGARD DR. APT 1304 City: HOUSTON State/Province: TX Zip Code: 77082

CLP/CDL Applicant/Holder: ● Yes ○ No

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Form MCSA-5876 OMB No. 2126-0006 Expiration Date: 03/31/2025

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

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

13220928478124

CMV DRIVER CERTIFICATION

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Medical Examiner's Certificate Expiration Date: 9/28/2023

MEDICAL EXAMINER INFORMATION

Medical Examiner's Signature: [signature]

Medical Examiner's Telephone Number: (847) 378-8147

Date Certificate Signed: 9/28/2022

Medical Examiner's Name (please print or type): BRIAN KILKUS

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

Medical Examiner's State License, Certificate, or Registration Number: 038.012584

Issuing State: IL

National Registry Number: 1410813531

CMV DRIVER INFORMATION

Driver's Signature: [signature]

Driver's License Number: 12837431

Issuing State/Province: TX

Driver's Address

Street Address: 2503 PANAGARD DR. APT 1304 City: HOUSTON State/Province: TX Zip Code: 77082

CLP/CDL Applicant/Holder: ● Yes ○ No

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MEDICAL EXAMINER'S CERTIFICATE

THIS MEDICAL EXAMINER'S CERTIFICATE HAS BEEN COMPLETED IN COMPLIANCE WITH
49 CFR PART 391 OF THE FEDERAL MOTOR CARRIER SAFETY REGULATIONS
BY THE CERTIFIED MEDICAL EXAMINER REGISTERED IN THE NATIONAL REGISTRY

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

Medical Examination Report Form
(for Commercial Driver Medical Certification)

MEDICAL RECORD #
13220928478124
(or sticker)

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

PERSONAL INFORMATION

Last Name: ROBINSON First Name: REGINALD Middle Initial: D Date of Birth: 04/16/1967 Age: 55

Street Address: 2503 PANAGARD DR. APT 1304 City: HOUSTON State/Province: TX Zip Code: 77082

Driver's License Number: 12837431 Issuing State/Province: TX Phone: (832) 490-6444

E-Mail *(optional)*: _____ CLP/CDL Applicant/Holder*: ◉ Yes ○ No

Driver ID Verified By**: CDL

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**

2000:L KNEE; MENISCUS REPAIR.

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

ASA 81MG. AMLODIPINE. VALSTARTAN. SYMPTUZA.

Last Name: ROBINSON First Name: REGINALD DOB: 04/16/1967 Exam Date: 09/28/2022

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

HIV.

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

High blood pressure: 1989:ONSET. /

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: [signature] Date: 09/28/2022

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).

THE DRIVER DENIES ANY SYMPTOMS.

13220928478124

Last Name: ROBINSON First Name: REGINALD DOB: 04/16/1967 Exam Date: 09/28/2022

TESTING

Pulse Rate: 72 Pulse rhythm regular: (●) Yes ( ) No Height: 5 *feet* 9 *inches* Weight: 205 *pounds*

Blood Pressure	Systolic	Diastolic
Sitting	118	78
Second reading *(optional)*		

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.015	0	0	NEGATIVE

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

Other testing if indicated

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/____	20/30	Right Eye: >70 degrees
Left Eye:	20/____	20/20	Left Eye: >70 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	Right Ear	Left Ear
Record distance *(in feet)* from driver at which a forced whispered voice can first be heard	> 5 FT	> 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	Normal	Abnormal	Body System	Normal	Abnormal
1. General	(●)	( )	8. Abdomen	(●)	( )
2. Skin	(●)	( )	9. Genito-urinary system including hernias	(●)	( )
3. Eyes	(●)	( )	10. Back/spine	(●)	( )
4. Ears	(●)	( )	11. Extremities/joints	(●)	( )
5. Mouth/throat	(●)	( )	12. Neurological system including reflexes	(●)	( )
6. Cardiovascular	(●)	( )	13. Gait	(●)	( )
7. Lungs/chest	(●)	( )	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.

13220928478124

Last Name: ROBINSON First Name: REGINALD DOB: 04/16/1967 Exam Date: 09/28/2022

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)*: UNDER MEDICAL CARE FOR BP.

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: _____

Medical Examiner's Name *(please print or type)*: BRIAN KILKUS

Medical Examiner's Address: 1654 GREENLEAF AVE. City: ELK GROVE VILLAGE State: IL Zip Code: 60007

Medical Examiner's Telephone Number: (847) 378-8147 Date Certificate Signed: 09/28/2022

Medical Examiner's State License, Certificate, or Registration Number: 038.012584 Issuing State: IL

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

☐ Other Practitioner *(specify)*: _____

National Registry Number: 1410813531

Medical Examiner's Certificate Expiration Date: 09/28/2023

13220928478124

Dr. Brian Kilkus
(Doctor Of Chiropractic)

Email Website Direction

Practice Business Name
MedStop

Address
1654 Greenleaf Ave Elk Grove Village, IL 60007

Hours of Operation
-

National Registry Number
1410813531

Certification Date
05/24/2014

Distance
N/A

Business Phone
(847) 378-8147

Business Fax Number
8473788174

Business Email
bjkilkus@gmail.com