

Public Burden Statement

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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:

First Name:

- ☒ 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 391.63) (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

04/10/2025

Medical Examiner's Signature

Medical Examiner's Name (please print or type)

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

Medical Examiner's Telephone Number

Date Certificate Signed

- ☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse
- ☐ DO ☒ Chiropractor ☐ Other Practitioner (specify) _____

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

Street Address: 0290 NE 170th St City: Miami, FL State/Province: FL Zip Code: 33160

CLP/CDL Applicant/Holder

☒ Yes ☐ No

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 **Dr. Fritz Philippe (Doctor Of Chiropractic)**
Body Of Light Wellness Center
2500 Hollywood blvd 201 Hollywood, FL 33020
(754) 816-5976 [N/A](#) [Directions](#)

