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 the 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:** PESTANA LLANES **First Name:** ARMANDO 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, attests my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date: 04/04/2024

Medical Examiner's Signature

Medical Examiner's Telephone Number: (305) 888-6959

Date Certificate Signed: 04/04/2022

Medical Examiner's Name (please print or type): Anelka Escoto

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

Medical Examiner's State License, Certificate, or Registration Number: 9283850

Issuing State: FL

National Registry Number: 8251269823

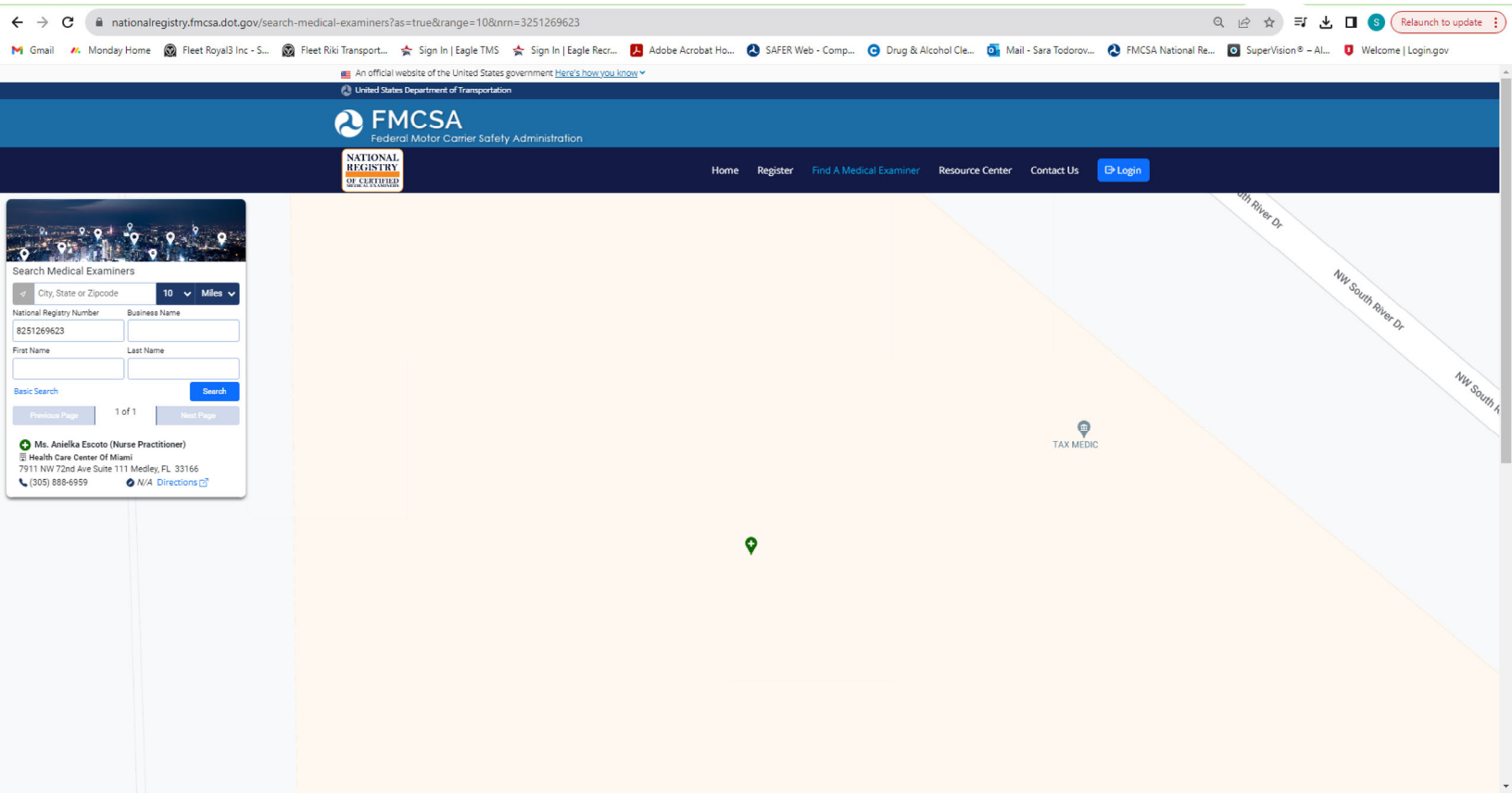
Driver's Signature

Driver's License Number: P236000812600

Issuing State/Province: FL

Driver's Address
Street Address: 1631 DREXEL RD LOT 19 City: WEST PALM BEACH State/Province: FL Zip Code: 33417

CLP/CDL Applicant Petitioner: (●) Yes ( ) No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Next Page
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Health Care Center Of Miami
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N/A
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