

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:** Acosta **First Name:** Jonathan 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 Certificate Expiration Date4/2/2027**Medical Examiner's Signature**SherriLynn Smith**Medical Examiner's Name (please print or type)**SherriLynn Smith**Medical Examiner's State License, Certificate, or Registration Number**209026521**Medical Examiner's Telephone Number**(708) 929-1569**Date Certificate Signed**4/2/2025

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

Issuing StateIL**National Registry Number**4808203971**Driver's Signature**[Signature]**Driver's License Number**A223420791781**Issuing State/Province**FL**Driver's Address**Street Address: 1311 briarritz drCity: MiamiState/Province: FLZip Code: 33141**CLP/CDL Applicant/Holder**☒ Yes ☐ No

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Mrs. SherriLynn Smith
(Advanced Practice Registered Nurse)

[Email](#)[Website](#)

Practice Business Name
Midwest Express Clinic

Address
3314 S Cicero Ave Unit B Cicero, IL 60804

Hours of Operation
-

National Registry Number	Certification Date
4808203971	06/15/2023

Distance	Business Phone
N/A	(708) 391-3030

Business Fax Number
-

Business Email
cicero@midwestexpressclinic.com

