

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: Sastre Izquierdo First Name: Joel 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 ☐ 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

Medical Examiner's Signature

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name (please print or type)

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

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

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

CLP/CDL Applicant/Holder

Street Address: 8505 TWIN LAKES BLVD City: TAMPA

State/Province: FL Zip Code: 33014 Yes ☒ No ☐

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 **Dr. Douglas Clearwater**
(Doctor Of Chiropractic)



Email



Website

Practice Business Name

Injury Health Center

Address

2901 West Busch Blvd Suite 807 Tampa, FL 33618

Hours of Operation

9a-4:30

National Registry Number

7114392130

Certification Date

05/17/2016

Distance

N/A

Business Phone

(813) 302-7246

Business Fax Number

8133245700

Business Email

tlkadc@gmail.com

