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:** Sacie Izquierdo **First Name:** Joel in accordance with *(please check only one)*:

(X) 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)*

Medical Examiner's Certificate Expiration Date 1/5/2025

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 Signature	**Medical Examiner's Telephone Number**	**Date Certificate Signed**
[signature]	813 302 7246	1/5/2024

Medical Examiner's Name *(please print or type)*: DOUGLAS CLEARWATER

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

Medical Examiner's State License, Certificate, or Registration Number	**Issuing State**	**National Registry Number**
CH89798	FL	7114392130

Driver's Signature	**Driver's License Number**	**Issuing State/Province**
[signature]	S262-420-70-176-1	FL

Driver's Address Street Address: 8505 TWIN LAKES BLVD City: TAMPA State/Province: FL Zip Code: 33614

CLP/CDL Applicant/Holder (X) 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. Rev 3/29/22

←

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
tilkadc@gmail.com