

**Public Burden Statement**  
A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Office, Federal Motor Carrier Safety Administration, MC-RPA, 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)

**CMV DRIVER CERTIFICATION**

I certify that I have examined (last name) Cuellar-Sanchez (first name) Harol L. 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 (specify type): \_\_\_\_\_
- ☐ Wearing hearing aid ☐ 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, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date 2/16/2024

**MEDICAL EXAMINER INFORMATION**

Medical Examiner's Signature

*[Signature]*

Medical Examiner's Name (please print or type)

DR. ILL. NAM, D.C.

Medical Examiner's Telephone Number

(702)870-7582

Date Certificate Signed

02/16/2024

☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse

☐ DO ☒ Chiropractor ☐ Other Practitioner (specify) \_\_\_\_\_

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

B01417

National Registry Number

3893701410

**CMV DRIVER INFORMATION**

Driver's Signature

*[Signature]*

Driver's License Number

514416524

Issuing State/Province

NM

Driver's Address

3109 Menonah Ave SE #C  
City: Albuquerque

State/Province:

NM



Zip Code:

87123

CLP/CDL Applicant/Holder

☒ 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.

[Login](#)

(Doctor Of Chiropractic)



Email



Website

## Sunny Hills Pain Clinic

Address

505 S. DECATUR BLVD. LAS VEGAS, NV 89107

9am-6pm

**Certification Date**  
05/09/2018

**Business Phone**  
(702) 870-7582

## 7028707583

[sunnyhillspainclinic@yahoo.com](mailto:sunnyhillspainclinic@yahoo.com)

