

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 this collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting burden 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, and comments regarding this 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-809, 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: **Torres** First Name: **Pedro Ariel** In accordance with (please check only one):
☒ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-41.45) 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 391.41-41.45) 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 391.41.42) (Federal)
☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPB) Certificate ☐ Qualified by operation of 49 CFR 391.41.43 (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

06/22/2025

Medical Examiner's Signature: **[Signature]** Medical Examiner's Telephone Number: **610-624-7773** Date Certificate Signed: **06/22/2023**
Medical Examiner's Name (please print or type): **Jesse Estrada**
☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse
☐ DO ☒ Chiropractor ☐ Other Practitioner (specify) _____
Medical Examiner's State License, Certificate, or Registration Number: **015519** Issuing State: **KS** National Practitioner Number: **4698677913**

Driver's Signature: **[Signature]** Driver's License Number: **1680-661-73-391-0** Issuing State/Province: **FL**
Driver's Address: **6525 W 24th Ave Apt. 101** City: **Hialeah** State/Province: **FL** Zip Code: **33016** ☒ CDL Applicant/Holder
Street Address: _____ City: _____ State/Province: _____ Zip Code: _____ ☐ Yes ☒ No

