

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 if it does not display this OMB Control Number. The OMB Control Number for this information collection is 2120-0006. Public reporting burden for this collection of information is estimated to be 1 hour per response, including the time for reviewing instructions, gathering the data needed, reviewing the collection of information, and reviewing the collection of information. All responses to this collection of information are voluntary and shall not be subject to any penalty for failure to respond. 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 584, 1200 New Jersey Avenue SE, Washington, DC 20003.

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: Santana Gonzalez

First Name: Yudel

in accordance with (please check only one)

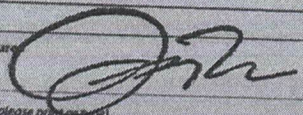
☒ the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) ☐ I find this person is qualified, and, if applicable, only when (check all that apply):

- ☐ Wearing corrective lenses ☐ Accompanied by a _____ waiver/exemption ☐ Driving within an exempt intracity zone (49 CFR 391.53) (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)

Medical Examiner's Certificate Expiration Date:

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.

01-04-26

Medical Examiner's Signature: 

Medical Examiner's Telephone Number

713-213-7803

Date Certificate Signed

01-04-24

Medical Examiner's Name (please print name)

DR. JENNY T. LE

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

DC09174TX

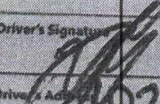
- ☐ MD ☐ Physician Assistant ☐ Advanced Practice Nurse
☐ DO ☒ Chiropractor ☐ Other Practitioner (specify) _____

Issuing State

TX

National Registry Number

4762579227

Driver's Signature: 

Driver's License Number

41883800

Issuing State/Province

TX

Driver's Address

Street Address

City

State

Zip

Country

Other

Notes

Comments

Remarks

Signature

Date

Time

Place

Other

Notes

Comments

Remarks

Signature

Date

Time

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Comments

Remarks

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Dr. Jenny Le
(Doctor Of Chiropractic)

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

Practice Business Name
Wellness & Drivers Physical Clinic

Address
440 Benmar Dr., Ste. 1020 Houston, TX 77060

Hours of Operation
mon - fri: 9 - 5 pm

National Registry Number 4762579227 **Certification Date** 04/19/2014

Distance N/A **Business Phone** (281) 741-3575

Business Fax Number 7133574833

Business Email dr.jennyle@msn.com

Business Website www.dotphysical101.com

