NATIONAL REGISTRY OF CERTIFIED MEDICAL EXAMINERS

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Jean Gaetano (Advanced Practice Registered Nurse)
HEALTH GROUP CENTER
141 N 6TH STREET HAINE CITY, FL 33844
(863) 353-1538 N/A Directions

Jean Gaetano (Nurse Practitioner)
UHS Primary Care Walton, NY
2 Titus Place Walton, NY 13856
(607) 865-2400 N/A Directions

U.S. DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

1200 NEW JERSEY AVENUE, SE

WASHINGTON, DC 20590

1-800-832-5660

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OMB No.: 2126-0006 Expiration Date: 03/31/2026

Form MCSA-5876

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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:** Turner **First Name:** Brandon 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 12/12/2025

Medical Examiner's Signature _____

Medical Examiner's Telephone Number 863-353-1538

Date Certificate Signed 12/12/2023

Medical Examiner's Name *(please print or type)* JEAN M GAETANO

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

Medical Examiner's State License, Certificate, or Registration Number APRN949689

Issuing State Florida

National Registry Number 4345905349

Driver's Signature _____

Driver's License Number I656 062 95 3800

Issuing State/Province FL

Driver's Address
Street Address: 3643 Ryegrass Street City: Clermont State/Province: FL Zip Code: 34714

CLP/CDL Applicant/Holder ● Yes ○ No

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