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<input type="text" value="City, State or Zipcode"/>	<input type="text" value="10"/>	Miles
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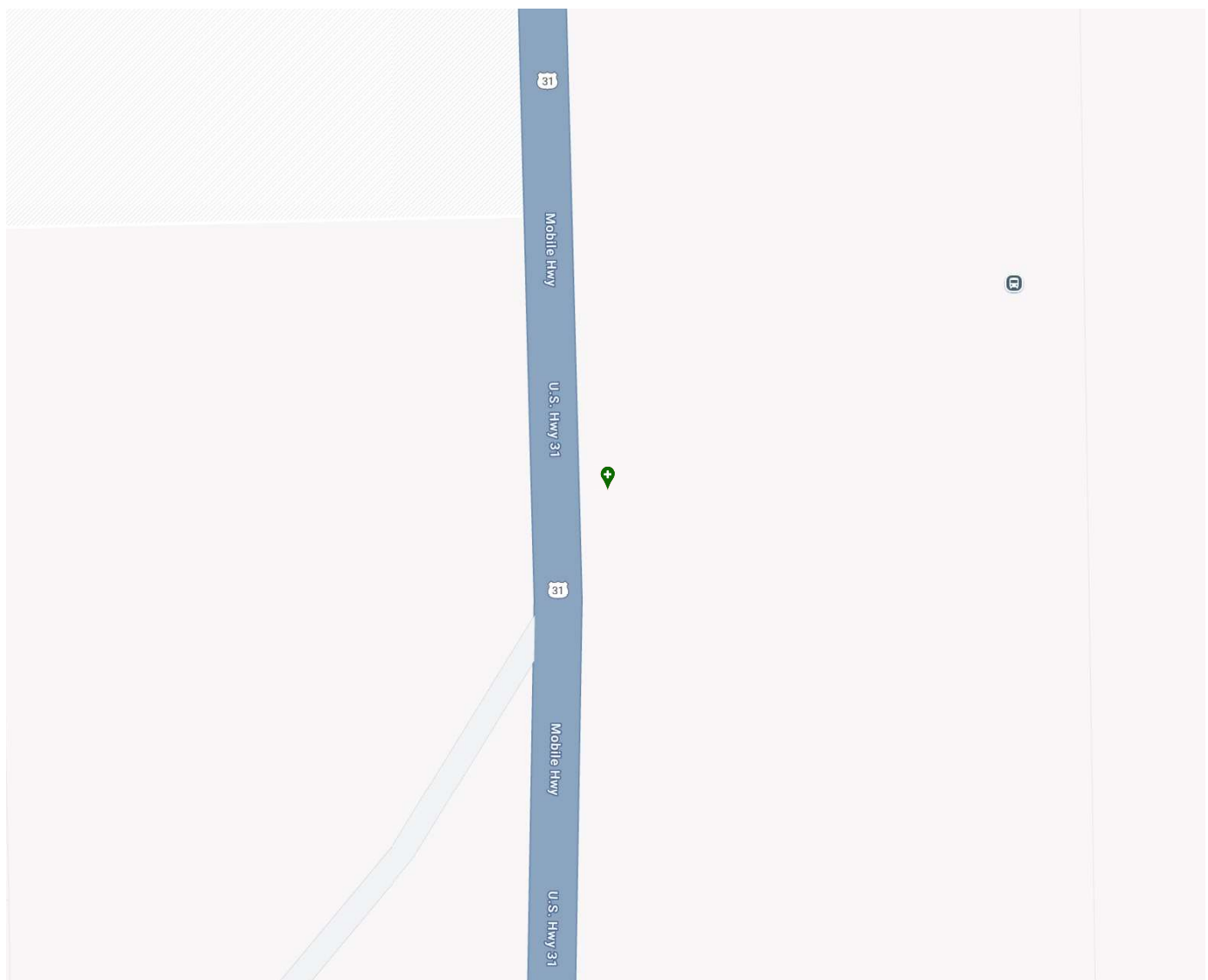
National Registry Number	Business Name
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First Name	Last Name
<input type="text"/>	<input type="text"/>

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 **Mr. Robert Samac (Nurse Practitioner)**  
 **Family Industrial Health Services**  
4725 Mobile Hwy Montgomery, AL 36108  
 (334) 281-3665  [N/A](#) [Directions?](#)





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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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Form MCSA-5876

OMB No.: 2126-0006 Expiration Date: 03/31/2025

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U.S. Department of Transportation  
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### Medical Examiner's Certificate

(for Commercial Driver Medical Certification)

I certify that I have examined Last Name: Hayes First Name: Nathanial ☒ 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, embodying my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date

1/10/2026

Medical Examiner's Signature

Medical Examiner's Name (please print or type)

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

Medical Examiner's Telephone Number

Date Certificate Signed

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

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

CLP/CDL Applicant/Holder

Street Address

City

State/Province

Zip Code

☒ Yes ☐ No

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Rev 3/23/22