A Redeal 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 corruptly with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid Control Number. The ONE Control Number for this information collection of information in estimated to be approximately one minute per response that collection of information displays a current valid Control Number. The ONE Control Number for this information are mandatory. Send comments regarding this burden estimate or any including the time for enviewing instructions, esthering instructions, esthering instruction, esthering instruction, esthering instruction completing and revolewing the collection of information. Including suggestions for reducing this burden to: Information Collection Conference Officer, Federal Motor Carrier Safety Administration, MC-899, 1200 New Jersey Avenue, 5E; Washington, D.C. 20599.

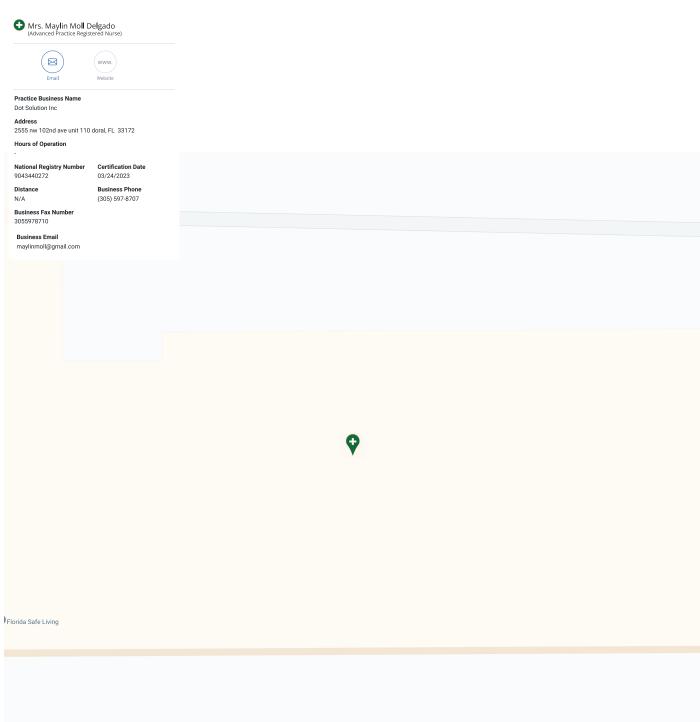
We discal Examiner's Certificate

(for Commercial Driver Medical Certification)

In accordance with (please check only one):

I certify that I have examined Last	Name: PEREZ	First Name:		The second second second		(please check only o	
the Federal Motor Carrier Safety the Federal Motor Carrier Safety find this person is qualified, an	Regulations (49 CTR 391.4	and, with knowledge of the age of	e driving duties, I fin ariances (which will	d this person is qua only be valid for int	lified, and, if ap trastate operati	oplicable, only when lons), and, with kno	n (check all that apply) OR whedge of the driving duties,
☐ Wearing corrective lenses ☐ Accompanied by a			The state of the s		nin an exempt	empt intracity zone (49 SER 391.82) (Federal)	
☐ Wearing hearing aid	☐ Accompanied by a Skill Performance Evaluation (SPE) Co			Qualified by operation of 49 CER 393.6A (Federal)			
				☐ Grandfathe	☐ Grandfathered from State requirements (State)		
					M	ledical Examiner's	Certificate Expiration Date
The information I have provided re	egarding this physical exam	nination is true and complete. A com	plete Medical Exam	ination Report Forr	n, [01	/04/2025	
MCSA-5875, with any attachments	i, embodies my findings co	mpletely and correctly, and is on file	in my office.		0.	70 11 20 20	
Medical Examiner's Signature Medical Examiner's Name (please print or type) Maylin Moll Delgado Medical Examiner's State License, Certificate, or Registration Number		tion Number	(305) 597-8707 OMD OPhysician Assistant ODO OChiropractor Issuing State		The property of the party of th	01/04/2024 Advanced Practice Nurse Other Practitioner (specify) National Registry Number	
APRN11024783			FL			9043440272	
Driver's Signature		A -	Driver's License Number P620001640290		Issuing State/Province		
Driver's Address Street Address: 5350 W 22h	ID LN APT3	City: HIALEAH		/Province: FL	71.	Code: 33016	CLP/CDL Applicant/Holde

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