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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: PEREZ** **First Name: ALEXIS** 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****01/04/2025****Medical Examiner's Signature****Medical Examiner's Telephone Number****(305) 597-8707****Date Certificate Signed****01/04/2024****Medical Examiner's Name (please print or type)****Maylin Moll Delgado**☐ MD ☐ Physician Assistant☒ Advanced Practice Nurse☐ DO ☐ Chiropractor☐ Other Practitioner (specify) \_\_\_\_\_**Medical Examiner's State License, Certificate, or Registration Number****APRN11024783****Issuing State****FL****National Registry Number****9043440272****Driver's Signature****Driver's License Number****P620001640290****Issuing State/Province****FL****Driver's Address****Street Address: 5350 W 22ND LN APT3****City: HIALEAH****State/Province: FL****Zip Code: 33016****CLP/CDL Applicant/Holder**☒ Yes ☐ No



 **Mrs. Maylin Moll Delgado**  
(Advanced Practice Registered Nurse)



Email



Website

**Practice Business Name**

Dot Solution Inc

**Address**

2555 nw 102nd ave unit 110 doral, FL 33172

**Hours of Operation**

-

**National Registry Number**

9043440272

**Certification Date**

03/24/2023

**Distance**

N/A

**Business Phone**

(305) 597-8707

**Business Fax Number**

3055978710

**Business Email**

maylinmoll@gmail.com

