

Last Name: MANZANET First Name: PETER DOB: 5/3/1996 Exam Date: 4/5/2024**Please complete only one of the following (Federal or State) Medical Examiner Determination sections:****MEDICAL EXAMINER DETERMINATION (Federal)***Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):*

- ☐ Does not meet standards (specify reason): _____
- ☒ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ☐ Meets standards, but periodic monitoring required (specify reason): _____
- Driver qualified for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ other (specify): _____
- ☒ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption (specify type): _____
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)
- ☐ Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- ☐ Determination pending (specify reason): _____
- ☐ Return to medical exam office for follow-up on (must be 45 days or less): _____
- ☐ Medical Examination Report amended (specify reason): _____
- (if amended) Medical Examiner's Signature: _____ Date: _____
- ☐ Incomplete examination (specify reason): _____

If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that, to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: L UgleMedical Examiner's Name (please print or type): Lindsey OgleMedical Examiner's Address: 6545 W Archer Ave City: Chicago State: IL Zip Code: 60638Medical Examiner's Telephone Number: (630) 974-6131 Date Certificate Signed: 4/5/2024Medical Examiner's State License, Certificate, or Registration Number: 277000082 Issuing State: IL☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☒ Advanced Practice Nurse☐ Other Practitioner (specify): _____National Registry Number: 1233736030Medical Examiner's Certificate Expiration Date: 4/5/2026

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+ Mrs. Lindsey Ogle
(Advanced Practice Registered Nurse)

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

Practice Business Name
First choice Immediate Care

Address
6545 W Archer Ave Chicago, IL 60638

Hours of Operation
-

National Registry Number	Certification Date
1233736030	06/03/2017

Distance	Business Phone
N/A	(630) 974-6131

Business Fax Number
-

Business Email
lindsey.arkus@gmail.com

