I certify that I have examined **Last Name:** ALVAREZ **First Name:** ROILAN 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 ☐ 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: 06/19/2026

Medical Examiner's Signature

Medical Examiner's Telephone Number: (305) 834-7900

Date Certificate Signed: 06/19/2024

Medical Examiner's Name *(please print or type)*: Jared Rose

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

Medical Examiner's State License, Certificate, or Registration Number: CH10847

Issuing State: Florida

National Registry Number: 4294143777

Driver's Signature

Driver's License Number: A416720893620

Issuing State/Province: Florida

Driver's Address

Street Address: 16625 SW 44 ST City: MIAMI State/Province: FL Zip Code: 33185

CLP/CDL Applicant/Holder: (•) Yes ( ) No

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.

Rev 3/13

Dr. Jared Rose
(Doctor Of Chiropractic)

Email Website

Practice Business Name
Sobe Health Center

Address
16585 nw 2 ave Suite #300 miami, FL 33169

Hours of Operation
-

National Registry Number
4294143777

Certification Date
04/30/2014

Distance
N/A

Business Phone
(305) 834-7900

Business Fax Number
7865230599

Business Email
jeru333@yahoo.com