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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: Solano First Name: Carlos 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)

Dr. Fritz J. Philippe

The information I have provided regarding this person's medical condition is true and correct. I have completed a complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and is on file in my office.

Medical Examiner's Certificate Expiration Date

05/25/2025

Medical Examiner's Signature

LIC # CH11400 DC

Medical Examiner's Telephone Number

Date Certificate Signed

Medical Examiner's Name (please print or type)

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

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

Issuing State

National Registry Number

Driver's Signature

Driver's License Number

Issuing State/Province

Driver's Address

Street Address:

City:

State/Province:

Zip Code:

CLP/CDL Applicant/Holder

☒ Yes ☐ No

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FMCSA

Federal Motor Carrier Safety Administration



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 **Dr. Fritz Philippe**
(Doctor Of Chiropractic)



Email



Website

Practice Business Name
Body of light Wellness Center

Address
2500 Hollywood blvd 201 Hollywood, FL 33020

Hours of Operation
8:30 am - 7:00 pm monday - friday. sat and sun per appointment

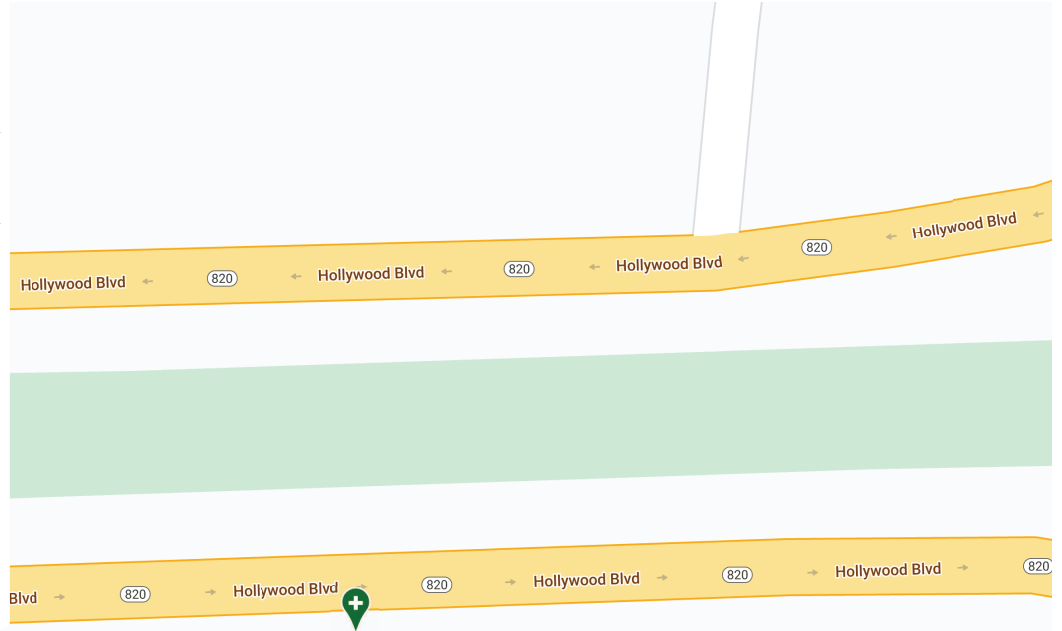
National Registry Number 1638823056 **Certification Date** 04/11/2015

Distance N/A **Business Phone** (754) 816-5976

Business Fax Number
-

Business Email
drphilippe1@yahoo.com

Business Website
<https://lightchiropracticcare.com/dot-exams/>



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