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U.S. Department of Transportation  
Federal Motor Carrier  
Safety Administration

### Medical Examiner's Certificate (for Commercial Driver Medical Certification)

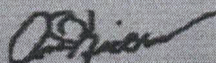
I certify that I have examined Last Name: **SAHBAZ** First Name: **JASMIN** in accordance with (please check only one):  
☒ the Federal Motor Carrier Safety Regulations (49 CFR 391.61, 391.63) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) OR  
☐ the Federal Motor Carrier Safety Regulations (49 CFR 391.61, 391.63) 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 391.63) 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)

Medical Examiner's Certificate Expiration Date

**3/10/2025**

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 Signature



Medical Examiner's Telephone Number

**(847) 380-8969**

Date Certificate Signed

**3/10/2023**

Medical Examiner's Name (please print or type)

**Anna Ricobene**

☐ MD ☐ Physician Assistant ☒ Advanced Practice Nurse  
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) \_\_\_\_\_

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

**209017865**

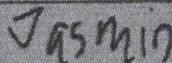
Issuing State

**IL**

National Registry Number

**4195509120**

Driver's Signature



Driver's License Number

**S12042087075**

Issuing State/Province

**IL**

Driver's Address

Street Address: **1775 W HIGHLAND AVE, APT 403** City: **CHICAGO** State/Province: **IL** Zip Code: **60660**

CLP/CDL Applicant/Holder

☒ Yes ☐ No

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 **Ms. Anna Ricobene**  
(Nurse Practitioner)



Email



Website

**Practice Business Name**

Midwest Express Clinic

**Address**

40 75th Street Willowbrook, IL 60527

**Hours of Operation**

-

**National Registry Number**

4195509120

**Certification Date**

03/06/2019

**Distance**

N/A

**Business Phone**

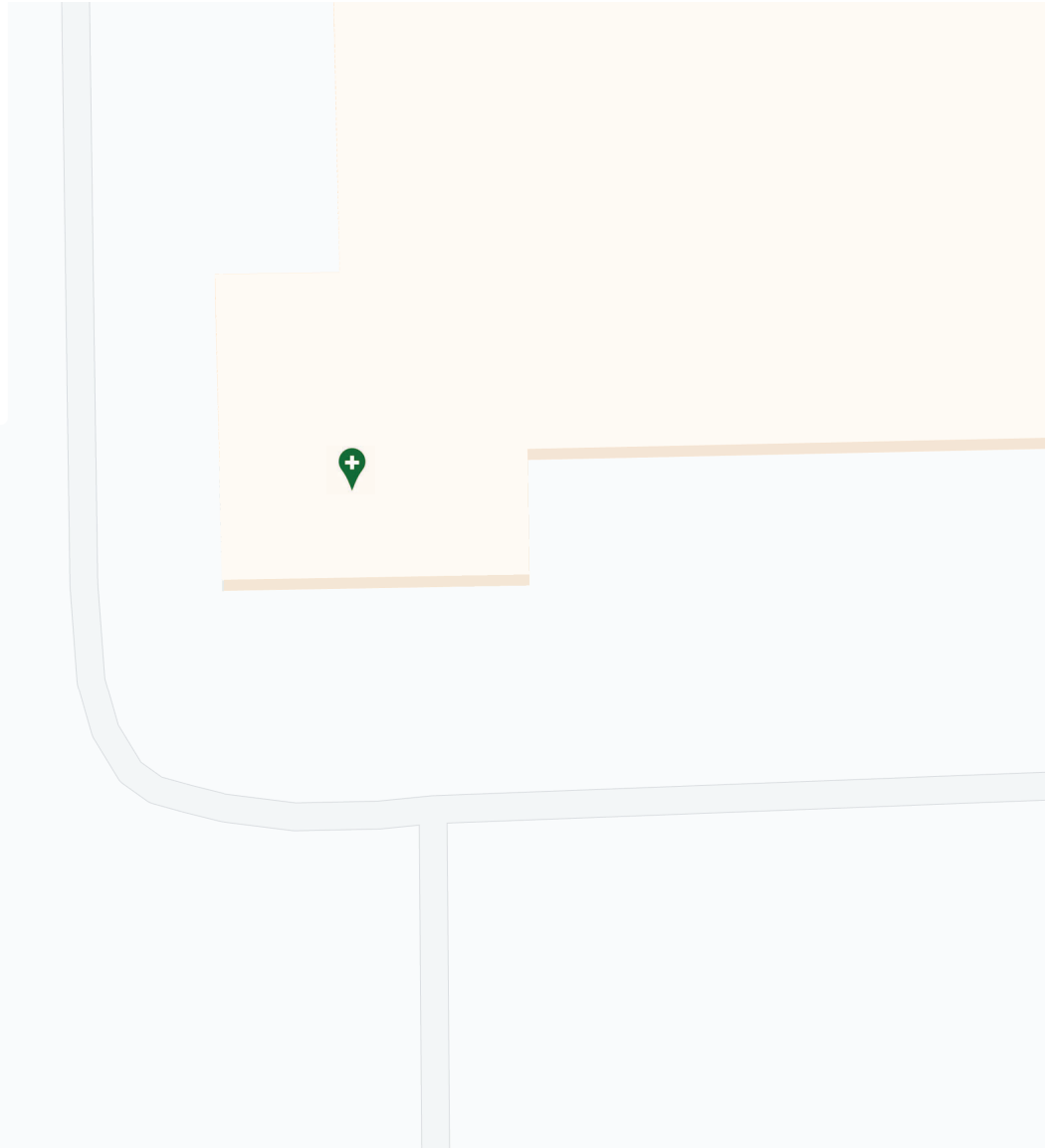
(630) 581-5372

**Business Fax Number**

-

**Business Email**

annaricobene@gmail.com



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U.S. DEPARTMENT OF TRANSPORTATION

**Federal Motor Carrier Safety Administration**

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