

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall it be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless this information collection is 2126-0006. Public reporting burden for this collection of information is estimated to be approximately one minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Office, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.

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

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

I certify that I have examined Last Name: Rodriguez First Name: Daniel 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 2875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date6/6/2025**Medical Examiner's Signature**

Jeremy Cosgriff
Medical Examiner's Name (please print or type)
G. Jeremy Cosgriff PA
Medical Examiner's State License, Certificate, or Registration Number
0110007730

Medical Examiner's Telephone Number540-490-2527**Date Certificate Signed**6/6/23☐ MD ☒ Physician Assistant ☐ Advanced Practice Nurse
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____**Issuing State**VA**National Registry Number**2772429514**Driver's Signature**Daniel Rodriguez**Driver's License Number**S63402416**Issuing State/Province**MA**Driver's Address**406 Nathan St**City:** Chicopee**State/Province:** MA**Zip Code:** 01020**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.

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