

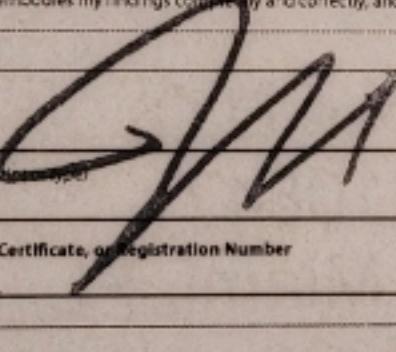
I certify that I have examined Last Name: CRAVEZ BECERRA First Name: ALEXIS in accordance with (please check only one):

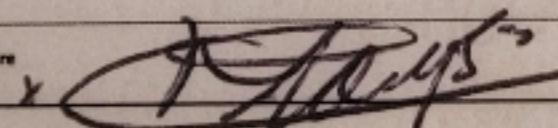
the Federal Motor Carrier Safety Regulations (49 CFR 391.61-391.66) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply):
 the Federal Motor Carrier Safety Regulations (49 CFR 391.61-391.66) with any applicable State variances (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 intrastate zone (49 CFR 395.6) (Federal)
 Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate Qualified by operation of 49 CFR 391.66 (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-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date
11/02/2024

Medical Examiner's Signature 	Medical Examiner's Telephone Number (305) 834-7900	Date Certificate Signed 11/03/2023
Medical Examiner's Name (please print or type) <u>Jared Rose</u>	<input type="radio"/> MD <input type="radio"/> Physician Assistant <input type="radio"/> Advanced Practice Nurse <input type="radio"/> DO <input checked="" type="radio"/> Chiropractor <input type="radio"/> Other Practitioner (specify) _____	
Medical Examiner's State License, Certificate, or Registration Number <u>CH10647</u>	Issuing State <u>Florida</u>	National Registry Number <u>4294143777</u>

Driver's Signature 	Driver's License Number <u>C121000733690</u>	Issuing State/Province <u>Florida</u>
Driver's Address Street Address: <u>605 WOODLAWN DR</u>	City: <u>SEBRING</u>	State/Province: <u>FL</u> Zip Code: <u>33870</u>
CDL/CDL Applicant/Holder <input checked="" type="radio"/> Yes <input type="radio"/> No		

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Rev. 1/3/2022

Form MCSA-5875

Last Name: CHAVEZ BECERRA

First Name: ALEXIS

DOB: 10/09/1973

Exam Date: 11/03/2023

TESTINGPulse Rate: 71 Pulse rhythm regular: Yes No

Height: 5 feet 9 inches Weight: 190 pounds

Blood Pressure		Systolic	Diastolic
Sitting		140	80
Second reading (optional)			

Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Urinalysis is required. Numerical readings must be recorded.	1.010	0	0	0

Other testing if indicated

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Vision

Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/____	20/20	Right Eye: 90 degrees
Left Eye:	20/____	20/20	Left Eye: 90 degrees
Both Eyes:	20/____	20/20	
			Yes <input checked="" type="radio"/> No <input type="radio"/>
			Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors <input checked="" type="radio"/> <input type="radio"/>
			Monocular vision <input type="radio"/> <input checked="" type="radio"/>
			Referred to ophthalmologist or optometrist? <input type="radio"/> <input checked="" type="radio"/>
			Received documentation from ophthalmologist or optometrist? <input type="radio"/> <input checked="" type="radio"/>

Hearing

Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB in better ear (with or without hearing aid).

Check if hearing aid used for test:	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear	<input checked="" type="checkbox"/> Neither
Whisper Test Results	Right Ear	Left Ear	
Record distance (in feet) from driver at which a forced whispered voice can first be heard	5	5	
OR			
Audiometric Test Results			
Right Ear:	500 Hz	1000 Hz	2000 Hz
Left Ear:	500 Hz	1000 Hz	2000 Hz
Average (right):			
Average (left):			

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	<input checked="" type="radio"/>	<input type="radio"/>	8. Abdomen	<input checked="" type="radio"/>	<input type="radio"/>
2. Skin	<input checked="" type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input checked="" type="radio"/>	<input type="radio"/>
3. Eyes	<input checked="" type="radio"/>	<input type="radio"/>	10. Back/spine	<input checked="" type="radio"/>	<input type="radio"/>
4. Ears	<input checked="" type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input checked="" type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input checked="" type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input checked="" type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input checked="" type="radio"/>	<input type="radio"/>	13. Gait	<input checked="" type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input checked="" type="radio"/>	<input type="radio"/>	14. Vascular system	<input checked="" type="radio"/>	<input type="radio"/>

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV.
Enter applicable item number before each comment.

LEFT GRIP STRENGTH 133 LBS
RIGHT GRIP STRENGTH 121 LBS
NECK DIAMETER: 17"
NO RHYTHM ABNORMALITIES DETECTED IN EKG
STOP BANG SCORE 1 MILD
BMI: 28.1

(Attach additional sheets if necessary)

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 23 minutes 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-IRB-A, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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

Medical Examination Report Form

(for Commercial Driver Medical Certification)

MEDICAL RECORD #

(or sticker)

SECTION 1. Driver Information (to be filled out by the driver)**PERSONAL INFORMATION**

Last Name: CHAVEZ BECERRA First Name: ALEXIS Middle Initial: Date of Birth: 10/09/1973 Age: 50
 Street Address: 605 WOODLAWN DR City: SEBRING State/Province: FL Zip Code: 33870
 Driver's License Number: C121000733690 Issuing State/Province: Florida Phone: (786) 661-7001
 E-Mail (optional): ACH2632@GMAIL.COM CLP/CDL Applicant/Holder*: Yes No
 Driver ID Verified By**: LICENSE

Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? Yes No Not Sure

*CLP/CDL Applicant/Holder: See instructions for definitions.

**Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

DRIVER HEALTH HISTORY

Have you ever had surgery? If "yes," please list and explain below.

Yes No Not Sure

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)? If "yes," please describe below.

Yes No Not Sure

LISINOPRIL

(Attach additional sheets if necessary)

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Dr. Jared Rose (Doctor Of Chiropractic)



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(305) 834-7900

N/A [Directions](#)



NW 183rd St

Miami Gardens Dr

860

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860