

**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 1 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 Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



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** Hill **First Name** Samuel 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):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Wearing corrective lenses      | <input type="checkbox"/> Accompanied by a _____ waiver/exemption                         | <input type="checkbox"/> Driving within an exempt intracity zone (49 CFR 391.62) (Federal) |
| <input checked="" type="checkbox"/> Wearing hearing aid | <input type="checkbox"/> Accompanied by a Skill Performance Evaluation (SPE) Certificate | <input type="checkbox"/> Qualified by operation of 49 CFR 391.64 (Federal)                 |
|   |  | <input type="checkbox"/> Grandfathered from State requirements (State)                     |

Medical Examiner's Certificate Expiration Date

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.

09/04/2022

Medical Examiner's Signature

\_\_\_\_\_

Medical Examiner's Name (please print or type)

Rosebrook, Sophia

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

0054681

Medical Examiner's Telephone Number

(303)755-4955

Date Certificate Signed

09/04/2020

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

Issuing State

CO

National Registry Number

2727691171

Driver's Signature

\_\_\_\_\_

Driver's Address

Street Address: 14720 E. Kentucky Dr #636

Driver's License Number

991520546

Issuing State/Province

CO

CLP/CDL Applicant/Holder

City: AURORA    State/Province: CO    Zip Code: 80012     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.\*\*

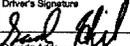
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**Medical Examiner's Certificate**  
By Governmental Order: Health & Paratransit

I certify that I have examined **Last Name: Hill** **First Name: Samuel** in accordance with (please check only one):  
 the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.43) 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 391.41-391.43) 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-5875, with any attachments embodies my findings completely and correctly, and is on file in my office. **Medical Examiner's Certificate Expiration Date: 09/04/2022**

<b>Medical Examiner's Signature</b>  _____ <small>Print Name (Please print or type)</small> Rosebrook, Sophia	<b>Medical Examiner's Telephone Number</b> 303755-4955	<b>Date Certificate Signed</b> 09/04/2020
<b>Medical Examiner's State License, Certificate, or Registration Number</b> 0054581	<input type="checkbox"/> MD <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Practice Nurse <input checked="" type="checkbox"/> DO <input type="checkbox"/> Chiropractor <input type="checkbox"/> Other Practitioner (Specify) _____	<b>Issuing State</b> CO
		<b>National Registry Number</b> 2727691171

<b>Driver's Signature</b>  _____ <small>Print Name</small> _____	<b>Driver's License Number</b> 991520546	<b>Issuing State/Province</b> CO
<b>Street Address:</b> 14720 E. Kentucky Dr #536	<b>City:</b> AURORA	<b>State/Province:</b> CO
	<b>Zip Code:</b> 80012	<b>CLP/CDL Applicant/Holder</b> <input type="radio"/> Yes <input checked="" type="radio"/> No

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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: Hill First Name: Samuel Middle Initial: E Date of Birth: 11/23/1983 Age: 36  
 Street Address: 14720 E. Kentucky Dr #636 City: AURORA State/Province: CO Zip Code: 80012  
 Driver's License Number: 991520546 Issuing State/Province: CO Phone: (303)829-0942 Gender:  M  F  
 E-mail (optional): Samuel.hill83@comcast.net CLP/CDL Applicant/Holder\*:  Yes  No  
 Driver ID Verified By\*\*: Drivers 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

Left Ankle with 2 screws put in

Are you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)?  Yes  No  Not Sure

If "yes", please describe below.

(Attach additional sheets if necessary)

Last Name: Hill First Name: Samuel DOB: 11/23/1983 Exam Date: 09/04/2020

**DRIVER HEALTH HISTORY (continued)**

Do you have or have your ever had:	Not				Not		
	Yes	No	Sure		Yes	No	Sure
1. Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems Insulin used	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Other health condition(s) not described above:  Yes  No  Not Sure

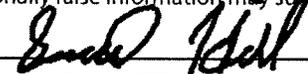
Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below.  Yes  No  Not Sure

Q4b - It's my right ear... I have a cross over hearing aid that I wear daily. Happened 15 years ago. I only got hearing aids about 3 years ago.; Q28 - Left ankle along with 2 screws put in year 2002;

*(Attach additional sheets if necessary)*

**CMV DRIVER'S SIGNATURE**

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature:  Date: 9/4/2020 9:23:43 AM

**SECTION 2. Examination Report (to be filled out by the medical examiner)**

**DRIVER HEALTH HISTORY REVIEW**

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

Q4 - Passed hearing test, hx of recurrent infections as a child; Q28 - left ankle surgery in 2002, no issues since then ;

*(Attach additional sheets if necessary)*

Last Name: Hill First Name: Samuel DOB: 11/23/1983 Exam Date: 09/04/2020

**TESTING**

Pulse rate: 90 Pulse rhythm regular:  Yes  No Height: 6 feet 4 inches Weight: 148 pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting	100	60	Urinalysis is required. Numerical readings must be recorded.	1.030	Trace	Negat	Negati
Second reading (optional)							

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/ 13            20/ \_\_\_\_\_      Right Eye: 90 degrees

Left Eye:     20/ 13            20/ \_\_\_\_\_      Left Eye: 90 degrees

Both Eyes:   20/ 13            20/ \_\_\_\_\_

**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:  Right Ear  Left Ear  Neither

**Whisper Test Results**

Record distance (in feet) from driver at which a forced whispered voice can first be heard

	Right Ear	Left Ear
	<u>5</u>	<u>5</u>

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors  Yes  No

Monocular vision  Yes  No

Referred to ophthalmologist or optometrist?  Yes  No

Received documentation from ophthalmologist or optometrist?  Yes  No

**OR**

**Audiometric Test Results**

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	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.

(Attach additional sheets if necessary)

Last Name: Hill First Name: Samuel DOB: 11/23/1983 Exam Date: 09/04/2020

**Please complete only one of the following (Federal or State) Medical Examiner Determination sections:**

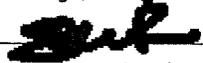
**MEDICAL EXAMINER DETERMINATION (Federal)**

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- Does not meet standards (specify reason): \_\_\_\_\_
- Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- Meets standards, but periodic monitoring required (specify reason): \_\_\_\_\_  
 Driver qualified for:  3 months  6 months  1 year  other (specify): \_\_\_\_\_
- Wearing corrective lenses  Wearing hearing aid  Accompanied by a waiver/exemption (specify type): \_\_\_\_\_
- Accompanied by a Skill Performance Evaluation (SPE) Certificate  Qualified by operation of 49 CFR 391.64 (Federal)
- Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)
- Determination pending (specify reason): \_\_\_\_\_  
 Return to medical exam office for follow-up on (must be 45 days or less): \_\_\_\_\_  
 Medical Examination Report amended (specify reason): \_\_\_\_\_  
 (if amended) Medical Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_
- Incomplete examination (specify reason): \_\_\_\_\_

**If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: 

Medical Examiner's Name (please print or type): Rosebrook, Sophia

Medical Examiner's Address: 10355 E Iliff Ave City: Aurora State: CO Zip Code: 80247-3622

Medical Examiner's Telephone Number: (303)755-4955 Date Certificate Signed: 09/04/2020

Medical Examiner's State License, Certificate, or Registration Number: 0054681 Issuing State: CO

MD  DO  Physician Assistant  Chiropractor  Advanced Practice Nurse

Other Practitioner (specify): \_\_\_\_\_

National Registry Number: 2727691171

Medical Examiner's Certificate Expiration Date: 09/04/2022

## Additional Notes Addendum

Last Name: Hill

First Name: Samuel

DOB: 11/23/1983

Exam Date: 09/04/2020

### DRIVER HEALTH HISTORY

Surgery (continued):

Left Ankle with 2 screws put in

Medications (continued):

Health History Yes Answers(continued):

Q4b - It's my right ear... I have a cross over hearing aid that I wear daily. Happened 15 years ago. I only got hearing aids about 3 years ago.; Q28 - Left ankle along with 2 screws put in year 2002;

Other Health Conditions (continued):

Examiner Comments (continued):

Q4 - Passed hearing test, hx of recurrent infections as a child; Q28 - left ankle surgery in 2002, no issues since then ;

### PHYSICAL EXAMINATION

### OTHER TESTING

Glucose Meter Measurements ( mg/dl):

Neck Circumference: (Inches): 13.5

BMI: 18

Additional comments for abnormal urine values:

Protein - trace;

Last Name: Hill

First Name: Samuel

DOB: 11/23/1983

Exam Date: 09/04/2020

**CERTIFICATION**

Does Not Meet Standards (continued):

Monitoring required due to (continued):

Reason Text (continued):