



FAXED

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security
E-Verify

Report Prepared: 10/04/2010
Page: 1 of 1

Case Verification Number: 2010277111937XB

Initial Verification:

Last Name:	St George	First Name:	William
Middle Initial:		Maiden Name:	
Social Security Number:	*** ** 1050	Date of Birth:	02/04/1968
Hire Date:	09/24/2010	Citizenship Status:	A citizen of the United States
Alien Number:		I-94 Number:	
Document Type:	List B and C Documents	Doc. Expiration Date:	
Submitted By:	ESAG6409	Submitted On:	10/04/2010

Initial Verification Results:

Initial Eligibility: Employment Authorized

SSA Referral:

Referral By: Referral Date:

Verification Response:

Eligibility: Response Date:

SSA Resubmittal:

Last Name:	First Name:
Middle Initial:	Maiden Name:
Social Security Number:	Date of Birth:
Submitted By:	Submitted On:

Resubmittal Verification Results:

Eligibility:

Additional Verification:

Comments:
Submitted By: Submitted On:

Verification Response:

Eligibility: Response Date:

DHS Referral:

Referral By: Referral Date:

DHS Referral Results:

Eligibility: Response Date:

Photo Matching Results:

Determination:

Additional DHS Referral:

Referral By: Referral Date:

Additional DHS Referral Results:

Eligibility: Response Date:

Case Resolution:

Resolve Option:	The employee continues to work for the employer after receiving an Employment Authorized result.		
Resolved By:	ESAG6409	Resolved On:	10/04/2010

SENSITIVE BUT UNCLASSIFIED

MINNESOTA
DRIVER'S LICENSE
COMMERCIAL



WILLIAM MICHAEL ST GEORGE
614 16TH ST NW
ROCHESTER, MN 55901

Date of Birth 02-04-1968
Sex Eyes Class
M BLU A
Height Weight
6-0 200

ISSUED 02-2007 EXPIRES 02-04-2011

X274243369013

William M. St George

SOCIAL SECURITY

472-74-1050

THIS NUMBER HAS BEEN ESTABLISHED FOR
WILLIAM M ST GEORGE

William M St George
SIGNATURE



FXED



9.29.10 2pm



ENTERED

Addendum to Application

APPLICANTS MAY BE TESTED FOR ILLEGAL DRUGS

PLEASE COMPLETE PAGES 1-4

DATE SEPT 24 2010

Name St. George, William Michael
Last First Middle Maiden

Social Security No. 472 - 74 - 1050

Telephone (507) 289-7227

If under 18, please list age _____

Referred by _____

Position applied for (1) ANY
and salary desired (2) neg
(Be specific)

Days/hours available to work
No Pref _____ Thur 3Rd
Mon 3Rd Fri 3Rd
Tue 3Rd Sat 3Rd
Wed 3Rd Sun 3Rd

How many hours can you work weekly? ANY Can you work nights? YES

Employment desired FULL-TIME ONLY ___ PART-TIME ONLY ___ FULL- OR PART-TIME

When available for work? SEPT 25 - 2010

Do you have responsibilities or commitments that will prevent you from meeting specified work schedules?
 No ___ Yes If so, please explain _____

Do you anticipate any absences from work on a regular basis?
 No ___ Yes If so, please explain _____

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (Complete mailing address)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School	<u>John Marshall</u>	<u>Rochester</u>	<u>12</u>	
College				
Bus. or Trade School	<u>Rtc</u>	<u>Rochester</u>	<u>1</u>	<u>Diesel mech</u>
Professional School				

HAVE YOU EVER BEEN CONVICTED OF A CRIME? No ___ Yes

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation. _____

WORK EXPERIENCE

Please list your work experience for the **past five years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**

Name <u>Progressive Truck Body</u>	Supervisor name <u>Glenn Bonnes</u>	
Position <u>Body Prep</u>	Employment dates	Pay or salary
Company _____	From <u>July 2007</u>	Start _____
Address <u>1115 Bandel Rd NW</u>	To <u>Jan 2009</u>	Final <u>15.00</u>
<u>Rochester, MN, 55901</u>	Your last job title <u>Body Prep</u>	
Telephone <u>(507) 281-1234</u>		

Reason for leaving (be specific) Laid off

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.

Name <u>Universal Bu and marine</u>	Supervisor name <u>Tim Wullenhouse</u>	
Position <u>Diesel mechanic</u>	Employment dates	Pay or salary <u>10.00</u>
Company _____	From <u>Jan 2007</u>	Start _____
Address <u>2850 Hwy 14 W</u>	To <u>Jun 2007</u>	Final <u>10.00</u>
<u>Rochester, MN 55901</u>	Your last job title <u>Diesel mechanic</u>	
Telephone <u>(507) 288-4000</u>		

Reason for leaving (be specific) no room for advancement

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this Company.

Name <u>Vertical Limits</u>	Supervisor name <u>Jonathan Schroeder</u>	
Position <u>TRUCK DRIVER</u>	Employment dates	Pay or salary
Company _____	From <u>sept 2005</u>	Start <u>18.00</u>
Address <u>811 3rd Ave</u>	To <u>oct 2006</u>	Final <u>18.00</u>
<u>Wahamingo, MN, 55983</u>	Your last job title _____	
Telephone <u>(507) 755-3216</u>		

Reason for leaving (be specific) Be Home more often - moving south

List the jobs you held, duties performed, skills used or learned, advancements or promotions while you worked at this company.

Who were you referred by? Donna Moore

May we contact your present employer? Yes ___ No

Did you complete this application yourself? Yes ___ No

If not, who did? _____

614 16th St NW
Rochester, Minnesota 55901
(507) 289-7227 Home
(507) 398-8228

William St. George

Employment and Experience

July 2007 – Jan 2009

Progressive Truck Body Repair

6115 Bandel Rd NW Rochester, MN 55901

(507) 281-1234

- Body Preparation
- Fiberglass Repair
- General Body Work

January 2007 – June 2007

Universal Marine and RV

2850 Hwy 14 W Rochester, MN 55901

(507) 288-4000

- Diesel Mechanic
- Body Work
- Paint Booth Operator

September 2005 – October 2006

Vertical Limits

Wanamingo, MN

(507) 824-1222

- Truck Driver
- Heavy Equipment Equipment

April 2005 – September 2005

Hanson Trucking

310 N State St West Concord, Minnesota 55985

(507) 527-2609

- Truck Driver
- Material Handler
- Mechanic

May 2003 – April 2005

Ames Construction

2000 Ames Drive Burnsville, Minnesota 55306

(952) 435-1706

- Truck Driver

May 2001 – May 2003

Hutton Drainage

18136 575th St West Concord, Minnesota 55985

(507) 527-2609

- Truck Driver
- Heavy Equipment Mechanic
- Installed Drainage Tile

Education

Graduated John Marshall High School
Rochester Community Technical College – Diesel Mechanic

Licenses

CDL with Tankers Endorsement – 1990 to Present
Minnesota DOT Inspector Certification - 2007

References

Jonathan Schroeder, Owner
Vertical Limits
811 3rd Avenue
Wanamingo, MN 55983
(651) 755-3216

Marvin Hanson, Owner
Hanson Trucking
310 North State Street
West Concord, MN 55985
(507) 527-2609

Gene Zimmerman, Owner
Zimmerman Farms
9485 60th Ave NW
Pine Island, MN 55963
(507) 273-6823



April 30, 2009

To Whom It May Concern:

Please accept this letter as a recommendation of employment for William St. George. William was employed with our company from September 20, 2005 through October 26, 2006. He worked for us in our Civil Operations Division as a Commercial Truck Operator. William had many duties that encompassed much more than his title would indicate. Besides semi-driving, he also operated heavy equipment and managed many jobsite processes. He was always looking forward to his work day and willing to accept new responsibilities with a positive attitude. He enjoyed the challenges that construction work offered and maintained an outstanding effort to getting the job done well and within the deadline.

William proved to be an independent, hard-working, and trustworthy individual with skills and knowledge in many facets of construction worksite operations and trucking operations. Also, I would like to note that his employment file contains several positive reviews and no safety violations.

I would highly recommend William St. George for any position you might be considering hiring him for that involves commercial truck driving or construction work as he repeatedly proved to be a trust-worthy, dependable, and loyal Employee while working under my direction at Vertical Limit Construction.

If you would like to discuss this recommendation further, please do not hesitate to contact me directly. I am most easily reached on my cell phone at 651-755-3216.

Respectfully yours,

A handwritten signature in black ink that reads "Jonathan P Schroeder". The signature is written in a cursive style with a long, sweeping underline.

Jonathan Schroeder
Owner

VERTICAL LIMIT CONSTRUCTION, LLC
811 3RD AVENUE, WANAMINGO, MN 55983
PHONE-507-824-1222 • FAX- 507-824-1223
EMAIL- INFO@VERTICALLIMIT.COM



Certificate of Completion

This is to certify that
WILLIAM ST. GEORGE

has successfully completed the Minnesota State Patrol's
vehicle inspection training course
which is designed to impart the necessary knowledge
to identify defective components as set forth in 49 CFR 396, Appendix G.

Inspector Certification Number 078981

February 1, 2007

Date

A handwritten signature in cursive script, appearing to read "Ken Urquhart".

Minnesota State Patrol

1TRANSFER TO: 20, 2009

03/20/2009

DV05 ** D.P.S. DRIVER LICENSE COMMERCIAL INQUIRY **

14:26:24

X27424369013

COMMERCIAL STATUS: VALID

HELP:

PAGE: 01

S-532 887-603-093

STATUS: VALID

CLASS: A TYPE: 1 SENIOR: MED: LIM-MOB:

ENDORS: N

DONOR: LIVING WILL: CORRECTIVE LENS:

B-CARD:

PHOTO BATCH: 2007771046042 DUPL BATCH: 2003771121006

NAME: WILLIAM MICHAEL ST GEORGE

BIRTH DATE: 02/04/1968

RESTR INFO: 3

ADDR: 614 16TH ST NW

CITY: ROCHESTER

COUNTY: 55

ZIP: 55901

MAILING ADDR:

EYES: BLU HEIGHT: 6-00 WEIGHT: 200 GENDER: M

SUSPENSE:

TICKLER:

DL ISSUE DATE: 02/16/2007 (B7) DL EXPIRE DATE: 02/04/2011

DNR:

- > 02/20/90 PASSED WT GK 01-26-90
- > 03/15/90 PASSED WT AIR, COM, 3-2-90
- > 01/08/91 PASSED WT GK, AIR, COM 1-7-91
- > 01/27/95 PSD WT C, H 1-26-95 (771) ES

NEXT REQUEST:

* LAW RESTRICTS ACCESS TO PERSONAL INFO

DEPARTMENT OF PUBLIC SAFETY - DRIVER LICENSE

DATE	03/20/2009	FRI
DL Record		\$9.00
TOTAL		\$9.00
CASH		\$10.00
CHANGE		\$1.00

THANK YOU! #01
 TIME 14:27 NO. 237094

1: TO: 20, 2009

03/20/2009

D ** D.P.S. DRIVER LICENSE COMMERCIAL INQUIRY **

14:26:27

X2 69013

COMMERCIAL STATUS: VALID

HELP:

PAGE: 02

S-5 87-603-093 WILLIAM MICHAEL ST GEORGE DOB: 02/04/1968 STAT: VALID

> 02/08/99 PSD WT T, H 1-28-99 771 MM

NEXT REQUEST:

** NO CONVICTIONS AND/OR CITATIONS WITHIN THE PAST FIVE (5) YEARS **

William St. George
2938 Jackson Landing Rd.
Picayune Ms, 39466

I was born in Rochester Mn. I have done bodywork on and off for 22 yrs. I was given the chance to move down south with some friends, to seek out my dreams to work in the marine industry. I am willing to relocate myself to where I might find employment. With this in mind I am looking for long term employment. I am currently living in Mississippi. I am willing to learn and I have no problems taking direction and doing things your way.

Thank you.
Sincerely,

A handwritten signature in cursive script that reads "William St. George". The signature is written in dark ink and is positioned to the right of the typed name "Sincerely,".

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined William St. George in accordance with 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:

- wearing corrective lenses
- wearing hearing aid
- accompanied by a _____ waiver/exemption
- driving within an exempt intracity zone (49 CFR 391.62)
- accompanied by a Skill Performance Evaluation Certificate (SPE)
- qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER <i>[Signature]</i>		TELEPHONE 507-374-6742	DATE 10/14/10
MEDICAL EXAMINER'S NAME (PRINT) Andrew T. Klein		<input type="checkbox"/> MD <input type="checkbox"/> DO <input checked="" type="checkbox"/> Chiropractor <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Practice Nurse	
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. / ISSUING STATE 4748 / MN			
SIGNATURE OF DRIVER <i>[Signature]</i>		DRIVER'S LICENSE NO. X27423369013	STATE MN
ADDRESS OF DRIVER 614 16 th St NW Rochester, MN 55901			
MEDICAL CERTIFICATE EXPIRATION DATE 10-14-2012			

MOTOR CARRIER COPY

SEPARATE MOTOR CARRIER COPY BEFORE REMOVING LINER FROM LAMINATE

Dodge Center Chiropractic

405 2nd Ave NW
Dodge Center, MN 55927

RECEIPT

DATE	10-14-10	No.	061750
RECEIVED FROM	William St. George		\$65 ⁰⁰
FOR	Sixty-five & 00/100		DOLLARS
<input type="radio"/> FOR RENT	DOT Physical		
<input type="radio"/> ACCOUNT			
<input type="radio"/> PAYMENT			
<input type="radio"/> BAL. DUE			
<input type="radio"/> CASH			
<input type="radio"/> MONEY ORDER			
<input checked="" type="radio"/> CHECK			
<input type="radio"/> CREDIT CARD			
BY	DT	8125	TO
	D. Klu		

Medical Examination Report

FOR COMMERCIAL DRIVER FITNESS DETERMINATION

649-F (Rev. 2/08) (10/11)

1. DRIVER'S INFORMATION

Driver completes this section.

Driver's Name (Last, First, Middle) <i>St. George William Mitchell</i>		Social Security No. <i>472-74-1090</i>	Birthdate <i>02-04-68</i>	Age <i>43</i>	Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> New Certification <input checked="" type="checkbox"/> Recertification <input type="checkbox"/> Follow Up	Date of Exam <i>10-14-10</i>
Address <i>614 16th St NW</i>	City, State, Zip Code <i>Rochester, MN, 55901</i>	Work Tel: <i>(507) 398-8228</i>	Driver License No. <i>X 2742 43369013</i>		License Class <input checked="" type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> B <input type="checkbox"/> D <input type="checkbox"/> Other	State of Issue <i>MN</i>	
Home Tel: <i>(507) 289-7227</i>							

2. HEALTH HISTORY

Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes		No		Yes		No		Yes		No	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Any illness or injury in the last 5 years?		Lung disease, emphysema, asthma, chronic bronchitis		Fainting, dizziness		Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring		Stroke or paralysis		Missing or impaired hand, arm, foot, leg, finger, toe	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Head/Brain injuries, disorders or illnesses		Kidney disease, dialysis		Diabetes or elevated blood sugar controlled by:		Chronic low back pain		Regular, frequent alcohol use		Narcotic or habit forming drug use	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Seizures, epilepsy <input type="checkbox"/> medication _____		Liver disease		Nervous or psychiatric disorders, e.g., severe depression <input type="checkbox"/> medication _____		Spinal injury or disease		Shortness of breath			
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Eye disorders or impaired vision (except corrective lenses)		Digestive problems		Loss of, or altered consciousness		Chronic low back pain					
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ear disorders, loss of hearing or balance		Diabetes or elevated blood sugar controlled by:				Regular, frequent alcohol use					
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart disease or heart attack; other cardiovascular condition <input type="checkbox"/> medication _____		Diet				Narcotic or habit forming drug use					
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Heart surgery (valve replacement/bypass, angioplasty, pacemaker)		Pills									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
High blood pressure <input type="checkbox"/> medication _____		Insulin									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Muscular disease		Nervous or psychiatric disorders, e.g., severe depression <input type="checkbox"/> medication _____									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Shortness of breath		Loss of, or altered consciousness									

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

northgate chiropractic, DR, Buchanan - last visit was ~1.5 yrs ago
Alcohol - only on weekends

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Driver's Signature

William St. George

Date

10-14-10

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving. This discussion must be documented below.)

Medications: *None*

Supplements: *None*

Tobacco: *pack/day*

TESTING (Medical Examiner completes Section 3 through 7) Name: Last, St-George First, William Middle, Michael

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

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. **Monocular drivers are not qualified.**

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/ <u>20</u>	20/	Right Eye <u>100</u> °
Left Eye	20/ <u>20</u>	20/	Left Eye <u>100</u> °
Both Eyes	20/ <u>20</u>	20/	

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

Applicant meets visual acuity requirement only when wearing: Corrective Lenses

Monocular Vision: Yes No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination _____ Name of Ophthalmologist or Optometrist (print) _____ Tel. No. _____ License No./State of Issue _____ Signature _____

4. HEARING Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB Check if hearing aid used for tests. Check if hearing aid required to meet standard.

INSTRUCTIONS: To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear <u>6</u> \Feet	Left Ear <u>6</u> \Feet
--	--------------------------	-------------------------

b) If audiometer is used, record hearing loss in decibels. (acc. to ANSI Z24.5-1951)	Right Ear			Left Ear		
	500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
	Average:			Average:		

5. BLOOD PRESSURE / PULSE RATE Numerical readings must be recorded. Medical examiner should take at least two readings to confirm BP.

Blood Pressure	Systolic <u>130</u>	Diastolic <u>78</u>
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Driver qualified if ≤ 140/90.

Pulse Rate: Regular Irregular

Record Pulse Rate: 76

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if ≤ 140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if ≤ 140/90
≥ 180/110	Stage 3	6 months from date of exam if ≤ 140/90	6 months if ≤ 140/90

6. LABORATORY AND OTHER TEST FINDINGS Numerical readings must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem. Other Testing (Describe and record)

URINE SPECIMEN	SP. GR. <u>1.025</u>	PROTEIN <u>Neg</u>	BLOOD <u>Neg</u>	SUGAR <u>Neg</u>
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