Public Burden Statement
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I certify that I have examined Last	Name: Bartson First Nam	e: Andrew Patrick in a	accordance with (please check only one):
the Federal Motor Carrier Safet	y Regulations (49 CFR 391.41-391.49) and, with knowledge of	the driving duties, I find this person is q	ualified, and, if applicable, only when (check all that apply) OR
	y Regulations (49 CFR 391.41-391.49) with any applicable Stat nd, if applicable, only when (check all that apply):	e variances (which will only be valid for	intrastate operations), and, with knowledge of the driving duties,
Wearing corrective lenses	Accompanied by a	_ waiver/exemption	vithin an exempt intracity zone (49 CFR 391.62) (Federal)
☐ Wearing hearing aid	☐ Accompanied by a Skill Performance Evaluation (SPE)	Certificate Grandfat	hered from State requirements (State)
			Medical Examiner's Certificate Expiration Date
	egarding this physical examination is true and complete. A co		orm, 06/10/2026
MCSA-5875, With any attachment	s, embodies my findings completely and correctly, and is on t	не in my опісе.	00/10/2020
Medical Examiner's Signature	Dary Bormein	Medical Examiner's Telephone N (510) 538-4414	Date Certificate Signed 06/10/2024
	0-190	·	06/10/2024
Medical Examiner's Name (pleas	0-190	(510) 538-4414	06/10/2024
Medical Examiner's Name (pleas	e print or type)	(510) 538-4414 O MD O Physician Assistan	06/10/2024 t O Advanced Practice Nurse
Medical Examiner's Name (pleas Daryl Berman Medical Examiner's State Licens	e print or type) .e, Certificate, or Registration Number	(510) 538-4414 OMD OPhysician Assistan ODO Chiropractor	06/10/2024 t OAdvanced Practice Nurse Other Practitioner (specify)
Medical Examiner's Name (pleas Daryl Berman Medical Examiner's State Licens	e print or type)	(510) 538-4414 ○ MD ○ Physician Assistan ○ DO ○ Chiropractor Issuing State	06/10/2024 t
Medical Examiner's Name (pleas Daryl Berman Medical Examiner's State Licens	e print or type) .e, Certificate, or Registration Number	(510) 538-4414 ○ MD ○ Physician Assistan ○ DO ○ Chiropractor Issuing State	06/10/2024 t
Medical Examiner's Name (pleas Daryl Berman Medical Examiner's State Licens 14313	e print or type) .e, Certificate, or Registration Number	(510) 538-4414 ○ MD ○ Physician Assistan ○ DO ○ Chiropractor Issuing State	06/10/2024 t
Medical Examiner's Name (pleas Daryl Berman Medical Examiner's State Licens 14313	e print or type) ee, Certificate, or Registration Number	(510) 538-4414 OMD OPhysician Assistan ODO Ochiropractor Issuing State CA	06/10/2024 t
Medical Examiner's Name (pleas Daryl Berman Medical Examiner's State Licens 14313	e print or type) ee, Certificate, or Registration Number	(510) 538-4414 ○ MD ○ Physician Assistan ○ DO ○ Chiropractor Issuing State CA Driver's License Number	06/10/2024 t

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.**

Form MCSA-5876 OMB No.: 2126-0006 Expiration Date: 03/31/2025

Public Burden Statement

2

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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 I	Name: Bartson	First Name:	Andrew Patrick	in acc	cordance with <i>(pi</i>	lease check only	one):
the Federal Motor Carrier Safety	Regulations (49 CFR 391.41-391.49) and, with known	wledge of the	driving duties, I find	d this person is qua	lified, and, if app	licable, only wh	en (check all that apply) OR
	Regulations (49 CFR 391.41-391.49) with any app d, if applicable, only when (check all that apply):	licable State va	riances (which will	only be valid for int	trastate operatior	ns), and, with kn	owledge of the driving duties,
Wearing corrective lenses	☐ Accompanied by a	v	waiver/exemption	☐ Driving witl	nin an exempt in	tracity zone (<u>49</u>	CFR 391.62)
☐ Wearing hearing aid	Accompanied by a Skill Performance Evalua	tion (SPE) Cert	ificate	☐ (Federal)) G	randfathered fro	m State require	ments (State)
	garding this physical examination is true and con embodies my findings completely and correctly,			nation Report Forn	n	dical Examiner 0/2026	's Certificate Expiration Date
Medical Examiner's Signature	Dary Borman		Medical Examine (510) 538-4414	r's Telephone Nur		ate Certificate 6/10/2024	Signed
Medical Examiner's Name (please	print or type)		OMD OP	nysician Assistant	O Advanced P	ractice Nurse	
Daryl Berman			•	niropractor	Other Pract	itioner (specify)	
Medical Examiner's State License	, Certificate, or Registration Number		Issuing State			ational Registr	
14313	-		CA			293030651	
Driver's Signature	Bato		Driver's License N	lumber	ls A	suing State/Pro	ovince
Driver's Address							CLP/CDL Applicant/Holder
Street Address: PO Box 1749	City: Peter	sburg	State/	Province: AK	Zip Cod	le: <u>94583</u>	Yes O 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.**

Public Burden Statement

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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 #

3184479

(or sticker)

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

PERSONAL INFORMATION	
Last Name: Bartson First Name: Andrew Patrick Middle Initial: Date of	of Birth: 01/08/1952 Age: 72
Street Address: PO Box 1749 City: Petersburg State/Provi	ince: AK Zip Code: 94583
Driver's License Number: 7841705 Issuing State/Province: AK	Phone: (707) 4835877
E-Mail (optional): cloudobserver@gmail.com CLP/CDL Applicant/Holder*: 0	∅ Yes ○ No
Driver ID Verified By**: CDL	
Has your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? O Yes 🛭 No (O Not Sure
*CLP/CDL Applicant/Holder: See instructions for definitions. **Driver ID Verified By: Record what type of photo ID was used to	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
Erleada 240 mg, 1 x day	

(Attach additional sheets if necessary)

Rev 2/28/2023 Page 1

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Form MCSA-5875

Do you have or have you ever had:	FORM MICSA-38/3		—	—		Омь но.: 2120-0000 ехриано			.,2022
Do you have or have you ever had: 1. Head/brain injuries or illnesses (e.g., concussion) 2. Seizures/epilepsy 3. Eye problems (except glasses or contacts) 3. Eye problems (except glasses or contacts) 4. Ear and/or hearing problems 5. Heart disease, heart attack, bypass, or other heart problems 6. Pacemaker, stents, implantable devices, or other heart problems 6. Pacemaker, stents, implantable devices, or other heart problems 7. High blood pressure 8. High cholesterol 9. Chronic (long-term) cough, shortness of breath, or other heart problems 9. Chronic (long-term) cough, shortness of breath, or other problems 10. Lung disease (e.g., critima) 11. Kidney problems, kidney stones, or pain/problems 12. Storden, muscle, joint, or nerve problems 13. Diabetes or load sugar problems 14. Kidney problems, kidney stones, or pain/problems 15. Thank, the problems 16. Lung disease (e.g., critima) 17. Have you ever thad a broken bone? 18. Limin used 19. Have you ever thad a broken bone? 19. Have you ever thad a broken bone? 19. Have you ever the day or do you now use tobacco? 10. Lung dispension, nervousness, other mental health problems 10. Ling dispension, nervousness, other mental health problems 10. Fainting or passing out 10. Fainting or passing out 11. Fainting or passing out 12. Forestate cancer treaded with radiation in April, 2024, UCDavis. Now on medication to prevent recocurrence. 12. Frostate cancer treaded with radiation in April, 2024, UCDavis. Now on medication to prevent recocurrence. 12. Frostate cancer treaded with radiation in April, 2024, UCDavis. Now on medication to prevent recocurrence.	Last Name: Bartson	First Name:	: <u>An</u>	<u>ıdre</u> v	w Patr	ick DOB: 01/08/1952 Exam Date: 06/10	/202	4	
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Other health condition(s) not described above: Other health condition(s) not		al health	0	Ø	0	two years?	0	Ø	0
Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: 23. Prostate cancer treaded with radiation in April, 2024, UCDavis. Now on medication to prevent reoccurrence. (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: 06/10/2024 Date: 06/10/2024 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	·		0	Ø	0		0	Ø	0
Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below: 23. Prostate cancer treaded with radiation in April, 2024, UCDavis. Now on medication to prevent reoccurrence. (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: 06/10/2024 Date: 06/10/2024 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	Other health condition(s) not described above:					○ Yes ⊗ No	. 0	Not	Sure
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: Date: D6/10/2024 Description of the 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		•					, 0	Not	Sure
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: 06/10/2024 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	20.1 Toolato carroot trouded with radiation in	2027, 002	avic.	140	On mou	ilication to provent recognitions.			
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: Date: 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									
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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. Date: 06/10/2024 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	CMV DRIVER'S SIGNATURE								
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	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								
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 Signature:	$\overline{\lambda}$				Date: 06/10/2024			
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									
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	SECTION 2. Examination Report (to be filled out l	by the medi	cal e>	xamir	ner)				
	<u>-</u>								
unversible operation of a commercial motor vertice (Civiv).			edica	ıl reco	rds. Con	nment on the driver's responses to the "health history" questions tha	at may	/ affe	ct the
He can perform all of duties at work.									
(Attach additional sheets if necessary)						(Attach additional sho	ets if n	0000	any)

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Last Name: Bartson First Name: Andrew Pat			rick DOB: <u>01/08/1952</u> Exam			m Date: <u>06/10/2024</u>			
TESTING									
Pulse Rate: <u>78</u>	Pulse rhythm regular:	⊗ Yes ○ No			Height: 5 feet 10 inche	s Weight: 1	70 pounds		
Blood Pressure	Systolic	Diasto	Diastolic		Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting	139	89	89		Urinalysis is required.	4.005			
Second reading (optional)	135	85			Numerical readings must be recorded.	1.005	negative	negative	negative
Other testing if indic	ated				Protein, blood, or sugar in th			on for further	testing to
rule out any underlying medical problem.									
At least 70° field of visio	40 acuity (Snellen) in each eye n in horizontal meridian mea l be noted on the Medical Exal	sured in each eye.	The use		Hearing Standard: Must first perceive hearing loss of less than or ed				
Acuity (Incorrected Corrected	Horizontal Fiel	d of Vi	ision	Check if hearing aid used	for test:	Right Ear	Left Ear 🏻	Neither
Right Eye: 2	0/_50_ 20/_25_	Right Eye: <u>85</u>	deg	grees	Whisper Test Results		biah a fana		ar Left Ear
Left Eye: 2	0/_50_ 20/_25_	Left Eye: 85	deg	grees	Record distance (in feet) fr whispered voice can first		wnich a forc	6	6
Both Eyes: 2	0/ <u>50</u> 20/ <u>25</u>		Yes	No	OR				
	nize and distinguish among howing red, green, and am		\otimes	0	Audiometric Test Result Right Ear:	S	Left Ear:		
Monocular vision			0	\otimes	500 Hz 1000 Hz 2	000 Hz	500 Hz	1000 Hz	2000 Hz
i i	nologist or optometrist?		0	\otimes					
Received documenta	ation from ophthalmologis	t or optometrist	? ()	⊗	Average (right):		Average (le	ft):	
PHYSICAL EXAMIN	IATION								
worsen, or is readily temporarily. Also, the condition could resu	amenable to treatment. Ev	en if a condition to take the nece	does essary	not di steps	particularly if the condition isqualify a driver, the Medic to correct the condition as	al Examiner	may conside	er deferring	the driver
Body System			Abnor		Body System			Normal	Abnormal
1. General 2. Skin		⊗ ⊗	0		 8. Abdomen 9. Genito-urinary system 	n includina h	ernias	⊗ ⊗	0
3. Eyes					10. Back/spine			\otimes	000000
4. Ears 5. Mouth/throat		⊗ ⊗ ⊗ ⊗	0000)	11. Extremities/joints 12. Neurological system i	ncludina ref	eves	⊗ ⊗ ⊗	0
6. Cardiovascular		Š			13. Gait	ricidaling ren	CACS	Š	ŏ
7. Lungs/chest		⊗	0		14. Vascular system			\otimes	0
	answers in detail in the space number before each commen		ite whe	ether it	would affect the driver's ability	to operate a	CMV.		

Page 3

(Attach additional sheets if necessary)

OMB No.: 2126-0006 Expiration Date: 03/31/2025

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

riease complete only one of the following (reaeral or State) medical Examiner	Determination sections:						
MEDICAL EXAMINER DETERMINATION (Federal)							
Use this section for examinations performed in accordance with the Federal Motor C	Carrier Safety Regulations (<u>49 C</u>	FR 391.41-391.49) :				
O Does not meet standards (specify reason):							
Meets standards in 49 CFR 391.41; qualifies for 2-year certificate							
O Meets standards, but periodic monitoring required (specify reason):							
Driver qualified for: O 3 months O 6 months O 1 year O other (specify	<i>)</i> :						
■ Wearing corrective lenses □ Wearing hearing aid □ Accompanie	ed by a waiver/exemption (spe	ecify type):					
☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate							
☐ Driving within an exempt intracity zone (see 49 CFR 391.62) (Federal)							
O 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:		_				
O Incomplete examination (specify reason):							
If the driver meets the standards outlined in 49 CFR 391.41, then complete a Med	lical Evaminor's Cortificato as sta		43(h) ac annronriato				
I have performed this evaluation for certification. I have personally reviewed all a evaluation, and attest that, to the best of my knowledge, I believe it to be true ar		d information pe	rtaining to this				
Medical Examiner's Signature:							
Medical Examiner's Name (please print or type): Daryl Berman							
Medical Examiner's Address: 1303 A Street	City: Hayward	State: CA	_ Zip Code: <u>94541</u>				
Medical Examiner's Telephone Number: (510) 538-4414	_ Date Certificate Signed: 06	3/10/2024					
Medical Examiner's State License, Certificate, or Registration Number: 14313			Issuing State: <u>CA</u>				
☐ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice N	Nurse						
☐ Other Practitioner (specify):							
National Registry Number: 2293030651	Medical Examiner's Certifica	ate Expiration Da	nte: 06/10/2026				