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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 it displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2120-0066. Public reporting burden 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. 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, NRC-80A, 1200 New Jersey Avenue, SE, Washington, DC 20020.

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

I certify that I have examined **Last Name: ZAPATA** **First Name: JORGE** 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 off 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 \_\_\_\_\_ waives/exemption ☐ Driving within an exempt intrastate zone (49 CFR 391.62) (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)

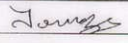
The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-1587, with any attachments embodies my findings completely and correctly, and is on file in my office.

**Medical Examiner's Signature**  **Medical Examiner's Telephone Number** **Date Certificate Signed**  
 (305) 888-6959 02/01/2021

**Medical Examiner's Name (please print or type)** **Medical Examiner's Title**  
 Kenia Carbonell ☐ MD ☐ Physician Assistant ☒ Advanced Practice Nurse

☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) \_\_\_\_\_

**Medical Examiner's State License, Certificate, or Registration Number** **Issuing State** **National Registry Number**  
 9339297 FL 8713200472

**Driver's Signature**  **Driver's License Number** **Issuing State/Province**  
 Z130433621680 FL

**Driver's Address** **City** **State/Province** **Zip Code** **CLP/CDL Applicant/Holder**  
 Street Address: 16440 SW 55TH TER City: MIAMI State/Province: FL Zip Code: 33185 ☒ Yes ☐ No