



I certify that I have examined Last Name: Alvarado First Name: Jesus 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):

Wearing corrective lenses Accompanied by a _____ waiver/exemption Driving within an exempt Intractivity 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: 8/13/2026

Medical Examiner's Signature: [Signature] Medical Examiner's Telephone Number: 425-316-5155 Date Certificate Signed: 8/13/2024

Medical Examiner's Name (please print or type): Dr. J. Karamchani

MD Physician Assistant Advanced Practice Nurse

DO Chiropractor Other Practitioner (specify) _____

Medical Examiner's State License, Certificate, or Registration Number: 60607481 Issuing State: WA National Registry Number: 9038212990

Driver's Signature: [Signature] Driver's License Number: [Redacted] Issuing State/Province: Washington

Driver's Address: Street Address: 1729 194th St SE #38 Bothell State/Province: Wn. Zip Code: 98012

CLP/CDL Applicant/Holder: Yes No

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