JACOB McGEE

DRIVER QUALIFICATION FILE
CHECKLIST 391.51

Requirement	Regulation
1. ✓ **Driver's Application for Employment** - A person will not be allowed to drive a commercial motor vehicle unless he/she has completed and signed an application for employment. NOTE: The application form must, as a minimum, contain the information in 391.21(b).	**49 CFR, 391.21**
2. ✓ **Driver Investigative History File** **- Documentation required by CFR Part 391.23 regarding the driver's Safety Performance History. Refer to Page #75.	**49 CFR, 391.53**
3. ✓ **Inquiry to State Agencies** - An investigation into the employee's driving record for the preceding three years. This investigation must be made within 30 days of the date his/her employment begins. mailed 2/9/17	**49 CFR, 391.21(a) (1) & (b)**
4. ✓ **Annual Review of Driving Record.** At least once every 12 months, a motor carrier must review the driving record of each driver. A note stating the results of this review shall be included in the driver's qualification file. At lease once every 12 months, a motor carrier must make an inquiry into the driving record of each driver.	**49 CFR, 391.25**
5. ✓ **Annual Driver's Certification of Violations.** At lease once every 12 months, a motor carrier must require each driver that it employs to prepare and furnish it with a list of all violations of motor vehicle traffic laws and ordinances during the previous 12 months.	**49 CFR, 391.27**
6. ✓ **Driver's Road Test and Certificate** (or equivalent). A person must not be allowed to drive a commercial motor vehicle until he/she has successfully completed a road test and has been issued a certificate, or a copy of the license or certificate that the motor carrier accepted as equivalent to the driver's road test, pursuant to section 391.33	**49 CFR, 391.31 & 33**
7. ✓ **Non-CDL Drivers & Self-Certified Intrastate CDL Drivers. Medical Examiner's Certificate.** The driver must pass a medical examination conducted by a certified medical examiner that is listed on the National Registry. A driver must be issued a medical examiner's certificate, which must be carried at all times, and renewed at least every two years. A copy of the medical certificate must be kept in the driver file. ____ **CDL Drivers (Interstate Only). Medical Examiner's Certificate.** The driver must pass a medical examination conducted by a certified medical examiner that is listed on the National Registry. A valid medical certificate can be used up to 15 days after issuance. After 15 days, the CDLIS motor vehicle record obtained from the current licensing state must be in the driver qualification file.	**49 CFR, 391.42 & 45 & 51** **See Exception Page 70**
8. ____ **LCV Certificate of Training or Certificate of Grand fathering.** A person must not be allowed to drive a LCV until he/she has been issued a LCV Driver-Training Certificate or a LCV Driver-Training Certificate of Grand fathering.	**49 CFR, 380.505 & 380.111**
9. ____ **Entry-Level Driver-Training Certificate** (CDL Driver only). A person must not be allowed to drive a CMV requiring a CDL without first obtaining the required Entry-Level Driver-Training Certificate.	**49 CFR, 380.500**
10. ✓ **Medical Examiner Verification**. Carriers must maintain in the driver's qualification file a note relating to verification of medical examiner listing on the National Registry of Certified Medical Examiners.	**49 CFR, 391.23(m)**

***The prospective motor carrier must:**

- Inform the applicant that the information provided on the application concerning previous employers may be used, and the applicant's previous employers will be contacted, for the purpose of investigating the applicant's safety performance history.
- Notify the driver in writing of his/her due process rights (see Due Process Rights in 391.23).

** Records must be maintained in secured location with controlled access.

STATE OF WASH. UTIL. AND TRANSP. COMMISSION
2017 APR -3 AM 9:12
RECORDS MANAGEMENT

WASHINGTON STATE DEPARTMENT OF LICENSING

Abstract of Driving Record
Release of Interest

Employer, prospective employer, or volunteer organization name: East County Senior Center

Agent business name if acting on behalf of the company for employment purposes: ____________

This is an authorization of:

1. Employee – for release of my driving record for employment purposes, at my employer's discretion for the full term of my employment; or
2. Prospective employee – for release of my driving record for employment purposes, not to exceed 30 days from date signed; or
3. Volunteer – for release of my driving record for a position applied for that requires me driving at the direction of the volunteer organization.

I, Jacob R. McGee (Your name), am an employee, prospective employee, or volunteer of the company named above and I request a copy of my official driving record in the state of Washington to my employer, prospective employer, volunteer organization, or their agent.

No employer, prospective employer, or their agent may use information contained in a driving record related to the sealed juvenile record of an employee or prospective employee for any purpose unless required by federal law. The employee or prospective employee must furnish a copy of the court order sealing the juvenile record to the employer, prospective employer, or their agent.

Employee/Prospective employee/Volunteer full name *(First, Middle, Last)*	Date of birth (mm/dd/yyyy)	WA driver license number
Jacob R. McGee	[redacted]	[redacted]
Employee/Prospective employee/Volunteer signature	**Date signed**	
X [signature]	02/03/2017	

The company listed below agrees to, and shall indemnify and hold harmless the state of Washington, Department of Licensing (DOL), the DOL Director, and all DOL employees from any and all suits at law or equity, and from any and all claims, demands or loss of any nature, including but not limited to all costs and attorney's fees, arising from any incorrect or improper disclosure of individual names or addresses under this "Release of Interest;" any defects in any of Company's procedures followed or omitted or arising from the failure of Company or its officers, employees, customers, contractors or agents to fulfill any of its obligations under this contract; or arising in any manner from any negligent act or omission by the company or its officers, employees, customers, contractors, or agents.

I hereby certify:

1. The company named below is an employer, prospective employer, or volunteer organization of the above-named individual.
2. The information contained in the abstracts of driver records obtained from DOL shall be used in accordance with the requirements and in no way violate the provisions of RCW 46.52.130. No information contained therein will be divulged, sold, assigned, or otherwise transferred to any third person or party. The abstracts of driver records shall be used exclusively for:

I affirm that I am a representative authorized to bind the company named below.

Company name	Authorized representative name	Title
East County Senior Center	Kate Miller	Program Coordinator
Address		
PO Box 602, 276 Sky River Parkway, Monroe, WA 98272		

02/03/2017 Monroe, WA
Date and place (city or county) signed

X [signature]
Authorized representative signature

NOTE: The employer or prospective employer must maintain this record for a period of not less than two (2) years from the date of the request. Failure to obtain all signatures or misuse of records obtained from the State of Washington may result in prosecution under RCW 46.52.130.

Form . ..A-5876 (Revised 12/06/2015) OMB No. 2126-0006 Expiration Date: 8/31/2018

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:** MCGEE **First Name:** JACOB in accordance with *(please check only one)*:

[x] 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
- [ ] Wearing hearing aid
- [ ] Accompanied by a ________ waiver/exemption
- [ ] Accompanied by a Skill Performance Evaluation (SPE) Certificate
- [ ] Driving within an exempt intracity zone (49 CFR 391.6) *(Federal)*
- [ ] Qualified by operation of 49 CFR 391.6 *(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: 02/10/2019

Medical Examiner's Signature

Medical Examiner's Telephone Number: 360-568-1541

Date Certificate Signed: 2/10/2017

Medical Examiner's Name *(please print or type)*: MICHAEL L BROWN, MD

[x] MD [ ] DO [ ] Physician Assistant [ ] Chiropractor [ ] Advanced Practice Nurse [ ] Other Practitioner *(specify)* ________

Medical Examiner's State License, Certificate, or Registration Number: MD00023171

Issuing State: WA

National Registry Number: 4867001168

Driver's Signature

Driver's License Number: [redacted]

Issuing State/Province: Washington

Driver's Address

Street Address: [redacted] City: [redacted] State/Province: WA Zip Code: [redacted]

CLP/CDL Applicant/Holder: [ ] Yes [x] No

M [crossed out]L BROWN MD @COMCAST, NET

VIOLATION AND REVIEW RECORD

Driver's Name JACOB McGee Employee Number N/A

CERTIFICATION OF VIOLATIONS

I certify that the following is a true and complete list of all traffic violations (including revocation, suspension or withdrawal of an operator's license, but not parking violations) for which I have been convicted or forfeited bond or collateral during the past 12 months.

DATE	OFFENSE	LOCATION	TYPE OF VEHICLE OPERATED
N/A			
N/A			
N/A			

Operator's License: (Revoked, Suspended, or Withdrawn) ______	Date: ______	Restored: ______
License Number:	State	Date: ______

If no violations are listed above, I certify that I have not been convicted or forfeited bond or collateral, during the past 12 months, because of any violation required to be listed.

______ Driver's Signature ______ 2/3/17 Date

______ Reviewed by: Signature ______ Title

______ Motor Carrier's Name ______ Motor Carrier's

REVIEW AND EVALUATION OF DRIVER'S RECORD

In accordance with Section 391.25 of the Federal Motor Carrier Safety Regulations, all information pertinent to the above driver's safety of operations, including the list of violations furnished by him/her in accordance with Section 391.27, has been reviewed for the past 12 months. Actions taken are detailed below (and on the reverse side of this form if additional room was necessary).

______ Reviewed by: Signature ______ Title ______ Date

(Form 9 – Rev. 10-2001)

APPLICATION FOR EMPLOYMENT

COMPANY EAST COUNTY SEN CTR STREET ADDRESS 276 SKY RIVER PRKWAY

CITY, STATE AND ZIP CODE MONROE WA 98272

APPLICANT'S NAME JACOB ROBERT McGEE
(First) (Middle) (Maiden Name, if any) (Last)

ADDRESS [redacted] HOW LONG? 2
(Street) (City) (State and Zip Code)

DATE OF BIRTH [redacted] PHONE [redacted] SOCIAL SECURITY NO. [redacted]

PAST ADDRESSES (previous three years)

	STREET	CITY	STATE & ZIP CODE	HOW LONG?
1	[redacted]	[redacted]	[redacted]	2 years
2	[redacted]	[redacted]	[redacted]	9 years
3				
4				

(ATTACH SHEET IF MORE SPACE IS NEEDED)

EXPERIENCE AND QUALIFICATIONS--DRIVER

DRIVER LICENSE	STATE	LICENSE NUMBER	TYPE	EXPIRATION DATE
	WA	[redacted]	Enhanced	1-17-2023

DRIVING EXPERIENCE

CLASS OF EQUIPMENT	TYPE OF EQUIPMENT (VAN,TANK,FLAT,ETC.)	DATES FROM	TO	APPROX. # OF MILES (TOTAL)
STRAIGHT TRUCK	Big Flat Bed	1996	present	1,000
TRACTOR/SEMI-TRAILER				
TRACTOR/2 TRAILERS				
OTHER:	VAN CUTAWAY (Senior Center Bus)	2005	present	5,000

ACCIDENT RECORD FOR PAST 3 YEARS OR MORE (ATTACH SHEET IF MORE SPACE IS NEEDED)

DATES	NATURE OF ACCIDENT (HEAD-ON, REAR-END, UPSET, ETC.)	FATALITIES	INJURIES
OCTOBER 2015	WAS REAR ENDED	N/A	N/A

(Form 2 Rev. 10-2001)

TRAFFIC CONVICTIONS AND FORFEITURES FOR THE PAST 3 YEARS (OTHER THAN PARKING VIOLATIONS)

LOCATION	DATE	CHARGE	PENALTY

(ATTACH SHEET IF MORE SPACE IS NEEDED)

A. Have you ever been denied a license, permit or privilege to operate a motor vehicle? YES________ NO________

B. Has any license, permit, or privilege ever been suspended or revoked? YES________ NO________

IF THE ANSWER TO EITHER A OR B IS YES, ATTACH A STATEMENT GIVING FULL DETAILS

EMPLOYMENT RECORD (Attach Sheet if More Space is Needed)

Note: DOT requires that employment for at least 3 years and/or Commercial Driving experience (CDL)for the past 10 years be shown.

LAST EMPLOYER NAME N/A Been here over 3 years

ADDRESS ________

POSITION HELD ________ FROM________ TO________ SALARY ________

REASON FOR LEAVING ________

Subject to Federal Motor Carrier Safety Regulations YES ______ NO ______

Performed safety sensitive function subject to DOT Controlled Substance/Alcohol testing YES ______ NO ______

SECOND LAST EMPLOYER NAME ________

ADDRESS ________

POSITION HELD ________ FROM________ TO________ SALARY ________

REASON FOR LEAVING ________

Subject to Federal Motor Carrier Safety Regulations: YES ______ NO ______

Performed safety sensitive function subject to DOT Controlled Substance/Alcohol testing YES ______ NO ______

THIRD LAST EMPLOYER NAME ________

ADDRESS ________

POSITION HELD ________ FROM________ TO________ SALARY ________

REASON FOR LEAVING ________

Subject to Federal Motor Carrier Safety Regulations: YES ______ NO ______

Performed safety sensitive function subject to DOT Controlled Substance/Alcohol testing YES ______ NO ______

TO BE READ AND SIGNED BY APPLICANT

This certifies that this application was completed by me, and that all entries on it and information in it are true and complete to the best of my knowledge.

2/3/17

(Date) (Applicant's Signature)

NOTE: A motor carrier may require an applicant to provide information in addition to the information required by the Federal Motor Carrier Safety Regulations.

(Form 2 - Rev. 1-2004)

SAFETY PERFORMANCE HISTORY RECORDS REQUEST

PART 1: TO BE COMPLETED BY PROSPECTIVE EMPLOYEE

I, (Print Name) JACOB R McGee [redacted]
First M.I. Last Social Security Number

Hereby authorize: [redacted]
Date of Birth

Previous Employer: ______ Email: ______

Street: ______ Telephone: ______

City, State, Zip: Been Here Fax No.: ______

To release and forward the information requested by section 3 of this document concerning my Alcohol and Controlled Substances Testing records within the previous 3 years from ______.
(employment application date)

over 3 years

To: Prospective Employer: ______

Attention: ______ Telephone: ______

Street: ______

City, State, Zip: ______

In compliance with §40.25(g) and 391.23(h), release of this information must be made in a written form that ensures confidentiality, such as fax, email, or letter.

Prospective employer's fax number: ______

Prospective employer's email address: ______

[signature] 2/3/17
Applicant's Signature Date

This information is being requested in compliance with §40.25(g) and 391.23.

PART 2: TO BE COMPLETED BY PREVIOUS EMPLOYER

ACCIDENT HISTORY

The applicant named above was employed by us. Yes ☐ No ☐

Employed as ______ from (m/y) ______ to (m/y) ______

1. Did he/she drive motor vehicle for you? Yes ☐ No ☐ If yes, what type? Straight Truck ☐ Tractor-Semitrailer ☐ Bus ☐ Cargo Tank ☐ Doubles/Triples ☐ Other (Specify) ______

2. Reason for leaving your employ: Discharged ☐ Resignation ☐ Lay Off ☐ Military Duty ☐
If there is no safety performance history to report, check here ☐, sign below and return.

ACCIDENTS: Complete the following for any accidents included on your accident register (§390.15(b)) that involved the applicant in the 3 years prior to the application date shown above, or check ☐ here if there is no accident register data for this driver.

	Date	Location	# Injuries	# Fatalities	Hazmat Spill
1.					
2.					
3.					

Please provide information concerning any other accidents involving the applicant that were reported to government agencies or insurers or retained under internal company policies: ______

Any other remarks: ______

Signature: ______

Title: ______ Date: ______

PREVIOUS EMPLOYER – COMPLETE PAGE 2 PART 3

PART 3:	TO BE COMPLETED BY PREVIOUS EMPLOYER

DRUG AND ALCOHOL HISTORY

If driver was not subject to Department of Transportation testing requirements while employed by this employer, please check here ☐, fill in the dates of employment from ______________ to ______________, complete bottom of Part 3, sign, and return.

Driver was subject to Department of Transportation testing requirements from ______________ to ______________.

1. Has this person had an alcohol test with the result of 0.04 or higher alcohol concentration?
   YES ☐ NO ☐
2. Has this person tested positive or adulterated or substituted a test specimen for controlled substances?
   YES ☐ NO ☐
3. Has this person refused to submit to a post-accident, random, reasonable suspicion, or follow-up alcohol or controlled substance test?
   YES ☐ NO ☐
4. Has this person committed other violations of Subpart B of Part 382, or Part 40?
   YES ☐ NO ☐
5. If this person has violated a DOT drug and alcohol regulation, did this person complete a SAP-prescribed rehabilitation program in your employ, including return-to-duty and follow-up tests? If yes, please send documentation back with this form.
   YES ☐ NO ☐
6. For a driver who successfully completed a SAP's rehabilitation referral and remained in your employ, did this driver subsequently have an alcohol test result of 0.04 or greater, a verified positive drug test, or refuse to be tested?
   YES ☐ NO☐

In answering these questions, include any required DOT drug or alcohol testing information obtained from prior previous employers in the previous 3 years prior to the application date shown on page 1.

Name: ______________________________

Company: ______________________________

Street: ______________________________

City, State, Zip: ______________________________ Telephone: ______________

Part 3 Completed by (Signature): ______________________________ Date: ______________

PART 4a:	TO BE COMPLETED BY PROSPECTIVE EMPLOYER

This form was (check one) ☐ Faxed to previous employer ☐ Mailed ☐ Emailed ☐ Other ______________

By: ______________________________ Date: ______________

PART 4b:	TO BE COMPLETED BY PROSPECTIVE EMPLOYER

Complete below when information is obtained.

Information received from: ______________________________

Recorded by: ______________________________ Method: ☐ Fax ☐ Mail ☐ Email ☐ Telephone

Date: ______________________________ ☐ Other ______________

INSTRUCTIONS TO COMPLETE THE SAFETY PERFORMANCE HISTORY RECORDS REQUEST

PAGE 1 PART 1: Prospective Employee
- Complete the information required in this section
- Sign and date
- Submit to the Prospective Employer

PAGE 2 PART 4a: Prospective Employer
- Complete the information
- Send to Previous Employer

PAGE 1 PART 2: Previous Employer
- Complete the information required in this section
- Sign and date
- Turn form over to complete SIDE 2 SECTION 3

PAGE 2 PART 3: Previous Employer
- Complete the information required in this section
- Sign and date
- Return to Prospective Employer

PAGE 2 PART 4b: Prospective Employer
- Record receipt of the information
- Retain the form

DRIVER'S ROAD TEST EXAMINATION

Driver's Name JACOB McGee Phone [redacted]

Driver's Address

City State Zip Code

The road test shall be given by the motor carrier or a person designated by it. However, a driver who is a motor carrier must be given the test by another person. The test shall be given by a person who is competent to evaluate and determine whether the person who takes the test has demonstrated that he or she is capable of operating the vehicle and associated equipment that the motor carrier intends to assign.

Rating of Performance 1 — 5 highest

Rating	Item
5	The pretrip inspection. (As required by Sec. 392.7)
N - A	Coupling and uncoupling of combination units, if the equipment he or she may drive includes combination units.
5	Placing the equipment in operation.
5	Use of vehicle's controls and emergency equipment.
5	Operating the vehicle in traffic and while passing other vehicles.
5	Turning the vehicle.
5	Braking, and slowing the vehicle by means other than braking.
5	Backing, and parking the vehicle.
	Other, Explain:

Type of equipment used in giving test: BUS

Date 2/10 2017 Examiner's Signature [signature]

If the road test is successfully completed, the person who gave it shall complete a certificate of driver's road test.

Remarks

JACOB MCCREE

CERTIFICATION OF ROAD TEST

Instructions to Carrier: If the road test is successfully completed, the person who gave it must complete the following certification in duplicate. The original of the signed road test form and the original of the Certification of Road Test shall be retained in the driver qualification file of the person who was examined, and duplicate copies provided to the person examined. Section 391.31 (e)(f)(g)(1)(2) of the Federal Motor Carrier Safety Regulations.

This is to certify that the above-named driver was given a road test under my supervision on 2/10 19-2017 consisting of approximately 3 miles of driving. It is my considered opinion that this driver possesses sufficient driving skill to operate safely the type of commercial motor vehicle listed above.

ECSC

(Carrier Name)

POB 602 MONROE 98272

(Carrier Address) (City) (State) (Zipcode)

LARRY HEWITT

(Name of Examiner) (Signature of Examiner)

WASHINGTON STATE DEPARTMENT OF LICENSING

CERTIFIED

Driving Record - [redacted]

Abstract of Complete Driving Record
This information is current as of 2/17/2017 3:50:32 PM

Driver information			
PIC	[redacted]		
Last	MCGEE	**Suffix**	
First	JACOB	**DOB**	[redacted]
Middle	ROBERT	**Gender**	Male

Driver license status	
Status	Clear
Issued	11/23/2016
Expires	1/17/2023
Original issue date	11/9/1994

Collisions

Accident date	Description	Accident report #	# of vehicles	# of injuries	# of fatalities	Case #	Vehicle class	Veh type	At fault
10/11/2015	Standing	E470305	4	1	0				

Driving Record Request

Use this form to request a driving record. We will send the record to you or the individual or company you indicate below. Mail this request and a **$13 non-refundable fee for each record requested** in a check or money order payable to Department of Licensing to:

Driver Records
Department of Licensing
PO Box 3907
Seattle, WA 98124-3907

For validation only

106-060-421-0005

If requesting a driving record for an employee, prospective employee, or volunteer, you must receive from them an **Abstract of Driving Record Release of Interest** (form DSC-425-020). Keep this Release of Interest in your files. DO NOT MAIL it to us.

Allow 2 weeks for processing. If you have additional questions, contact customer service at (360) 902-3900, option 6.

Requestor information

PRINT or TYPE Requestor name	(Area code) Daytime telephone number
East County Senior Center	(360) 794-6359
How would you like the driving record(s) sent? *(Choose one)* ☑ Email ☐ Fax ☐ U.S. mail (one record only)*	**We will not mail more than one driver record. Multiple record requests will only be sent by email or fax.*
Email or (Area code) Fax number delivery information: programs@eastcountyseniorcenter.org	
U.S. mail delivery *(Individual/Company name)*	
Mailing address *(Street address or PO Box, City, State, ZIP code)*	

Drive records requested

PRINT or TYPE Name *(Last, First, Middle initial)*	
McGee, Jacob R	
Date of birth	Washington driver license number
[redacted]	[redacted]

Type of record requested ***(If more than one record type selected, include $13 for each additional record)***

Insurance records show violations, convictions, and accidents only. Other drive records show all traffic-related collisions, convictions, violations, suspensions, revocations, and disqualifications. We offer the following types of driving records:

- ☐ **Noncommercial insurance record (3 year)**–Used to create and renew vehicle insurance policies.
- ☐ **Commercial insurance record (3 year)**–Used to create and renew commercial vehicle insurance policies.
- ☐ **Life insurance record (3 year)**–Used to create and renew life insurance policies.
- ☐ **Employment record**–Used by employers to determine employment eligibility.
- ☐ **Volunteer/Transit record**–Used to determine if a volunteer driver meets the insurance and risk-management requirements to drive a vanpool vehicle or should be permitted to operate a vehicle used to transport individuals who are under 18, over 65, or disabled.
- ☑ **Complete record**–A complete driving record of the person named on the driving record.

SIGN OR TYPE YOUR NAME – *By signing or typing your name, you are certifying under penalty of perjury that you are entitled by federal or state laws to obtain an abstract of the driver record of the individual requested. RCW 46.52.130, 18 USC Chapter 123*

02/03/2017
Date and place (city or county) signed

X [signature]
Signature

If requesting additional drive records, attach separate sheets using the same format as above. Include $13 for each record requested.

WASHINGTON

ENHANCED DRIVER LICENSE

4d LIC#

1 MCGEE

2 JACOB ROBERT

3 DOB

DONOR

4a Iss 11-23-2016

15 Sex M

16 Hgt 5-11

17 Wgt 160

18 Eyes GRN

9 Class

4b Exp 01-17-2023

9a End NONE

12 Restrictions NONE

5 DD

Form .‥‥-5876 (Revised 12/06/2015) OMB No. 2126-0006 Expiratic… te: 8/31/2018

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:** MCGEE **First Name:** JACOB in accordance with *(please check only one)*:

[x] 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
- [ ] Wearing hearing aid
- [ ] Accompanied by a ______ waiver/exemption
- [ ] Accompanied by a Skill Performance Evaluation (SPE) Certificate
- [ ] Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
- [ ] 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: 02/10/2019

Medical Examiner's Signature: [signature]

Medical Examiner's Telephone Number: 360-568-1541

Date Certificate Signed: 2/10/2017

Medical Examiner's Name *(please print or type)*: MICHAEL L BROWN, MD

[x] MD [ ] Physician Assistant [ ] Advanced Practice Nurse
[ ] DO [ ] Chiropractor [ ] Other Practitioner *(specify)* ______

Medical Examiner's State License, Certificate, or Registration Number: MD00023171

Issuing State: WA

National Registry Number: 4867001168

Driver's Signature: [signature]

Driver's License Number: [redacted]

Issuing State/Province: Washington

Driver's Address

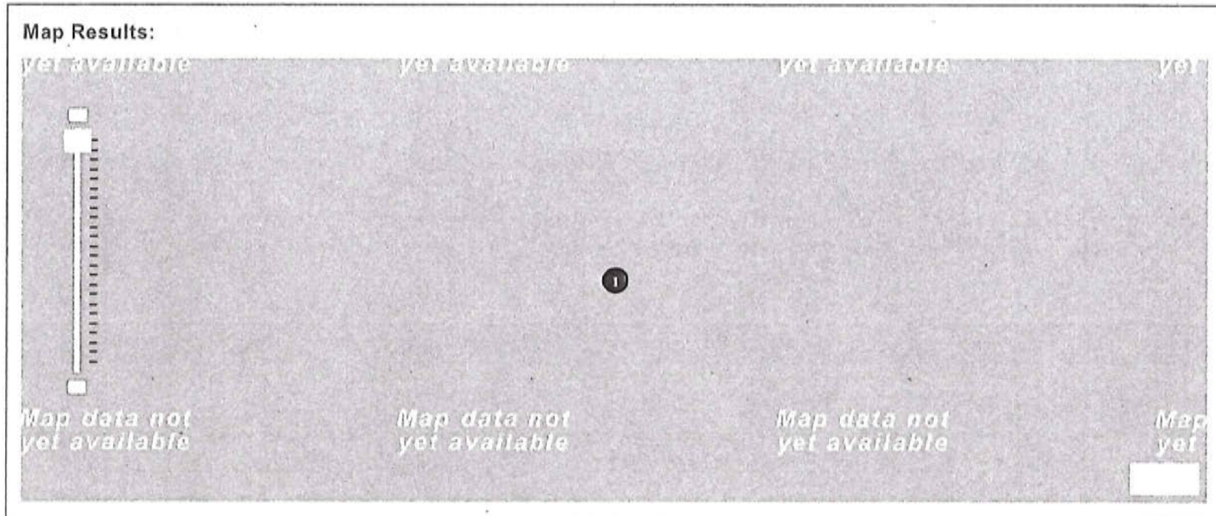
Street Address: [redacted] City: [redacted] State/Province: WA Zip Code [redacted]

CLP/CDL Applicant/Holder: [ ] Yes [x] No

Print

You searched for Medical Examiners with Michael Brown, NRID #4867001168, Profession: MD, snohomish, WA, Showing Results Page 1 of 1

Map Results:



1 **Michael L Brown** — 0.4 Miles
Medical Doctor , National Registry #: 4867001168
Certification Date: 4/26/2014

Flightsurgeon.com
Employer: Flightsurgeon.com
9900 Airport Way, Snohomish, WA, 98296
360-568-1541, Ext: 2 , Fax: 206-533-0474
Hours of Operation: 10am - 5pm

Website | Email | Get Directions

Search for Medical Examiner

Last Name: Brown
First Name: Michael
National Registry ID #: 4867001168
Business Name:
Employer Name:
Medical Profession: Medical Doctor (MD)
City: snohomish
State: WA
OR Zip Code
Radius: 25
Search