

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 one 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:** Mitchell **First Name:** John 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 intracity zone ([49 CFR 391.62](#)) *(Federal)*
 Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate 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

06/19/2025

Medical Examiner's Signature

Medical Examiner's Name *(please print or type)*

Pratt, Collette

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

MD00033927

Medical Examiner's Telephone Number

(425)774-8758

Date Certificate Signed

06/19/2024

- MD Physician Assistant Advanced Practice Nurse
 DO Chiropractor Other Practitioner *(specify)* _____

Issuing State

WA

National Registry Number

1011216561

Driver's Signature

Driver's Address

Street Address: 14056 23rd PL NE City: Seattle State/Province: WA Zip Code: 98125 Yes No

Driver's License Number

Wdlb55nd813b

Issuing State/Province

WA

CLP/CDL Applicant/Holder

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Street Address: 14056 23rd PL NE City: Seattle State/Province: WA Zip Code: 98125 Yes No **CLP/CDL Applicant/Holder**

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.