



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 Office, Federal Motor Carrier Safety Administration, MC-99A, 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:** FRIGOLA COTS **First Name:** LEO 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 ☐ 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-5675, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date

03/01/2024

Medical Examiner's Signature

Medical Examiner's Telephone Number
(305) 597-8707

Date Certificate Signed
03/01/2022

Medical Examiner's Name (please print or type)

Rosa Garcia Amaya

☐ MD ☐ Physician Assistant ☒ Advanced Practice Nurse
☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) _____

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

APRN11004448

Issuing State

FL

National Registry Number

7656543813

Driver's Signature

Driver's License Number

F624524923650

Issuing State/Province

FL

Driver's Address

Street Address: 3275 ROSTAN LN

City:

PALM SPRINGS

State/Province:

FL

Zip Code:

33461

CLP/CDL Applicant/Holder

☒ Yes ☐ No