

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined Milton Kelly in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties find this person is qualified; and if applicable, only when:

- ☐ wearing corrective lenses
- ☐ wearing hearing aid
- ☐ accompanied by a waiver/exemption
- ☐ driving within an exempt intracity zone (49 CFR 391.62)
- ☐ accompanied by a Skill Performance Evaluation Certificate (SPE)
- ☐ qualified by operation of 49 CFR 391.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly, and is on file in my office.

SIGNATURE OF MEDICAL EXAMINER <u>FLOYD E. MARSHALL</u>		TELEPHONE <u>443-524-2737</u>	DATE <u>2/23/16</u>
PHYSICIAN ASSISTANT CERTIFICATE <u>C-0000357 MD</u>		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Chiropractor	<input checked="" type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> Other Practitioner
MEDICAL EXAMINER'S LICENSE OR CERTIFICATE NO. / ISSUING STATE <u>0000357 MD</u>		NATIONAL REGISTRY NO. <u>7926254494</u>	
SIGNATURE OF DRIVER <u>[Signature]</u>		DRIVER'S LICENSE NO. <u>14-400-603-237-136</u>	STATE <u>MD</u>
ADDRESS OF DRIVER <u>1423 Embury St Baltimore MD 21202</u>		INTRASTATE ONLY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
MEDICAL CERTIFICATE EXPIRATION DATE <u>2/23/18</u>		CDL <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	