

Form MCSA-5876		OMB No. 2126-0006 Expiration Date: 11/30/2021	
<b>Public Burden Statement</b> <small>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.</small>			
U.S. Department of Transportation Federal Motor Carrier Safety Administration		<b>Medical Examiner's Certificate</b> <small>(for Commercial Driver Medical Certification)</small>	
I certify that I have examined <b>Last Name:</b> <u>Vukovic</u> <b>First Name:</b> <u>Mirsad</u> in accordance with (please check only one): <input checked="" type="radio"/> 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) <b>OR</b> <input type="radio"/> 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): <div style="display: flex; justify-content: space-between; font-size: x-small;"> <div> <input type="checkbox"/> Wearing corrective lenses    <input type="checkbox"/> Accompanied by a _____ waiver/exemption  <input type="checkbox"/> Wearing hearing aid    <input type="checkbox"/> Accompanied by a Skill Performance Evaluation (SPE) Certificate         </div> <div> <input type="checkbox"/> Driving within an exempt intracity zone (49 CFR 391.62) (Federal)  <input type="checkbox"/> Qualified by operation of 49 CFR 391.64 (Federal)  <input type="checkbox"/> Grandfathered from State requirements (State)         </div> </div>			
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.			<b>Medical Examiner's Certificate Expiration Date</b> 06/29/2023
<b>Medical Examiner's Signature</b>		<b>Medical Examiner's Telephone Number</b>	<b>Date Certificate Signed</b>
		(630) 972-0733	06/29/2021
<b>Medical Examiner's Name (please print or type)</b>		<input checked="" type="radio"/> MD <input type="radio"/> Physician Assistant <input type="radio"/> Advanced Practice Nurse <input type="radio"/> DO <input type="radio"/> Chiropractor <input type="radio"/> Other Practitioner (specify) _____	
<b>Medical Examiner's State License, Certificate, or Registration Number</b>		<b>Issuing State</b>	<b>National Registry Number</b>
036-113828		Illinois	5851616654
<b>Driver's Signature</b>		<b>Driver's License Number</b>	<b>Issuing State/Province</b>
		V212-5406-0013	Illinois
<b>Driver's Address</b>		<b>CLP/CDL Applicant/Holder</b>	
Street Address: 1661 A Vallley Forge Ct    City: Wheaton    State/Province: IL    Zip Code: 60189		<input checked="" type="radio"/> Yes <input type="radio"/> No	

\*\*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.\*\*



Office of the Secretary of State  
**Driver Services Department**

[www.cyberdriveillinois.com](http://www.cyberdriveillinois.com)

Name: **MIRSAD VUKOVIC**

Driver's License Number: **V212-5406-0013**

Date: **06-29-2021** Facility Number: **279** Operator Number: **C35**



**Non-excepted interstate** - [NI] Operates or expects to operate in interstate commerce and is both subject to and meets the requirements under (49 CFR part 391).



**Excepted interstate** - [EI] Operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted (school bus operations, federal and state employees, transportation of personal property, transportation of human corpses or sick and injured persons, operation of fire trucks and rescue vehicles while involved in emergency and related operations).



**Non-excepted intrastate** - [NA] Operates only in intrastate commerce and therefore is subject to State driver qualification requirements.



**Excepted intrastate** - [EA] Operates in intrastate commerce, but engages exclusively in transportation or operation excepted from all or parts of the State driver qualification requirements.

### Disclosure Statement

Under penalties of perjury, I swear or affirm that all information submitted by me regarding this self certification is true and accurate.

Signature

**Public Burden Statement**

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U.S. Department of Transportation  
Federal Motor Carrier  
Safety Administration

## Medical Examination Report Form

(for Commercial Driver Medical Certification)

**MEDICAL RECORD #***(or sticker)***SECTION 1. Driver Information** *(to be filled out by the driver)***PERSONAL INFORMATION**Last Name: Vukovic First Name: Mirsad Middle Initial: \_\_\_\_\_ Date of Birth: 01/13/1960 Age: 61Street Address: 1661 A Vallley Forge Ct City: Wheaton State/Province: IL Zip Code: 60189Driver's License Number: V212-5406-0013 Issuing State/Province: IL Phone: (630) 890-3025 Gender: ☒ M ☐ FE-mail (optional): \_\_\_\_\_ CLP/CDL Applicant/Holder\*: ☒ Yes ☐ NoDriver ID Verified By\*\*: CDLHas your USDOT/FMCSA medical certificate ever been denied or issued for less than 2 years? ☒ Yes ☐ No ☐ Not Sure

\*CLP/CDL Applicant/Holder: See instructions for definitions.

\*\*Driver ID Verified By: Record what type of photo ID was used to verify the identity of the driver, e.g., CDL, driver's license, passport.

**DRIVER HEALTH HISTORY**

Have you ever had surgery? If "yes," please list and explain below.

☐ Yes ☒ No ☐ Not SureAre you currently taking medications (prescription, over-the-counter, herbal remedies, diet supplements)?  
If "yes," please describe below.☐ Yes ☒ No ☐ Not Sure*(Attach additional sheets if necessary)*

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Last Name: VukovicFirst Name: MirsadDOB: 01/13/1960Exam Date: 06/29/2021**DRIVER HEALTH HISTORY (continued)**

Do you have or have you ever had:	Yes	No	Not Sure		Yes	No	Not Sure
1. Head/brain injuries or illnesses (e.g., concussion)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	16. Dizziness, headaches, numbness, tingling, or memory loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
2. Seizures, epilepsy	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	17. Unexplained weight loss	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
3. Eye problems (except glasses or contacts)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	18. Stroke, mini-stroke (TIA), paralysis, or weakness	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4. Ear and/or hearing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	19. Missing or limited use of arm, hand, finger, leg, foot, toe	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
5. Heart disease, heart attack, bypass, or other heart problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	20. Neck or back problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
6. Pacemaker, stents, implantable devices, or other heart procedures	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	21. Bone, muscle, joint, or nerve problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
7. High blood pressure	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	22. Blood clots or bleeding problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
8. High cholesterol	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	23. Cancer	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
9. Chronic (long-term) cough, shortness of breath, or other breathing problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	24. Chronic (long-term) infection or other chronic diseases	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
10. Lung disease (e.g., asthma)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	25. Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
11. Kidney problems, kidney stones, or pain/problems with urination	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	26. Have you ever had a sleep test (e.g., sleep apnea)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
12. Stomach, liver, or digestive problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	27. Have you ever spent a night in the hospital?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
13. Diabetes or blood sugar problems Insulin used	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	28. Have you ever had a broken bone?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
14. Anxiety, depression, nervousness, other mental health problems	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	29. Have you ever used or do you now use tobacco?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
15. Fainting or passing out	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	30. Do you currently drink alcohol?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				31. Have you used an illegal substance within the past two years?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
				32. Have you ever failed a drug test or been dependent on an illegal substance?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

Other health condition(s) not described above:

☐ Yes ☒ No ☐ Not Sure

Did you answer "yes" to any of questions 1-32? If so, please comment further on those health conditions below.

☐ Yes ☒ No ☐ Not Sure

(Attach additional sheets if necessary)

**CMV DRIVER'S SIGNATURE**

I certify that the above information is accurate and complete. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate, that submission of fraudulent or intentionally false information is a violation of 49 CFR 390.35, and that submission of fraudulent or intentionally false information may subject me to civil or criminal penalties under 49 CFR 390.37 and 49 CFR 386 Appendices A and B.

Driver's Signature: \_\_\_\_\_

Date: 06/29/2021**SECTION 2. Examination Report (to be filled out by the medical examiner)****DRIVER HEALTH HISTORY REVIEW**

Review and discuss pertinent driver answers and any available medical records. Comment on the driver's responses to the "health history" questions that may affect the driver's safe operation of a commercial motor vehicle (CMV).

(Attach additional sheets if necessary)

Last Name: Vukovic First Name: Mirsad DOB: 01/13/1960 Exam Date: 06/29/2021**TESTING**Pulse rate: 78 Pulse rhythm regular: ☒ Yes ☐ No Height: 5.0 feet 8.00 inches Weight: 190.0 pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting	138	84	Urinalysis is required. Numerical readings must be recorded.	1.005	negative (0)	negative (0)	negative (0)
Second reading (optional)							

Other testing if indicated

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

<b>Vision</b> Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.				<b>Hearing</b> Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40 dB, in better ear (with or without hearing aid).			
<b>Acuity</b>	Uncorrected	Corrected	Horizontal Field of Vision	Check if hearing aid used for test: <input type="radio"/> Right Ear <input type="radio"/> Left Ear <input checked="" type="radio"/> Neither			
Right Eye:	20/ <u>30</u>	20/ <u>    </u>	Right Eye: <u>85</u> degrees	<b>Whisper Test Results</b>			
Left Eye:	20/ <u>30</u>	20/ <u>    </u>	Left Eye: <u>85</u> degrees	Record distance (in feet) from driver at which a forced whispered voice can first be heard			
Both Eyes:	20/ <u>20</u>	20/ <u>    </u>	Yes <input checked="" type="radio"/> No <input type="radio"/>	Right Ear <u>5.0</u> Left Ear <u>5.0</u> <b>Audiometric Test Results</b> Right Ear Left Ear 500 Hz 1000 Hz 2000 Hz 500 Hz 1000 Hz 2000 Hz Average (right): <u>                    </u> Average (left): <u>                    </u>			
Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors <input checked="" type="radio"/> Yes <input type="radio"/> No							
Monocular vision <input type="radio"/> Yes <input checked="" type="radio"/> No							
Referred to ophthalmologist or optometrist? <input type="radio"/> Yes <input checked="" type="radio"/> No							
Received documentation from ophthalmologist or optometrist? <input type="radio"/> Yes <input checked="" type="radio"/> No							

**PHYSICAL EXAMINATION**

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even if a condition does not disqualify a driver, the Medical Examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible, particularly if neglecting the condition could result in a more serious illness that might affect driving.

Check the body systems for abnormalities.

Body System	Normal	Abnormal	Body System	Normal	Abnormal
1. General	<input checked="" type="radio"/>	<input type="radio"/>	8. Abdomen	<input checked="" type="radio"/>	<input type="radio"/>
2. Skin	<input checked="" type="radio"/>	<input type="radio"/>	9. Genito-urinary system including hernias	<input checked="" type="radio"/>	<input type="radio"/>
3. Eyes	<input checked="" type="radio"/>	<input type="radio"/>	10. Back/Spine	<input checked="" type="radio"/>	<input type="radio"/>
4. Ears	<input checked="" type="radio"/>	<input type="radio"/>	11. Extremities/joints	<input checked="" type="radio"/>	<input type="radio"/>
5. Mouth/throat	<input checked="" type="radio"/>	<input type="radio"/>	12. Neurological system including reflexes	<input checked="" type="radio"/>	<input type="radio"/>
6. Cardiovascular	<input checked="" type="radio"/>	<input type="radio"/>	13. Gait	<input checked="" type="radio"/>	<input type="radio"/>
7. Lungs/chest	<input checked="" type="radio"/>	<input type="radio"/>	14. Vascular system	<input checked="" type="radio"/>	<input type="radio"/>

Discuss any abnormal answers in detail in the space below and indicate whether it would affect the driver's ability to operate a CMV. Enter applicable item number before each comment.

(Attach additional sheets if necessary)

Last Name: Vukovic First Name: Mirsad DOB: 01/13/1960 Exam Date: 06/29/2021

Please complete only one of the following (Federal or State) Medical Examiner Determination sections:

**MEDICAL EXAMINER DETERMINATION (Federal)**

Use this section for examinations performed in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49):

- ☐ Does not meet standards (specify reason): \_\_\_\_\_
- ☒ Meets standards in 49 CFR 391.41; qualifies for 2-year certificate
- ☐ Meets standards, but periodic monitoring required (specify reason): \_\_\_\_\_
- Driver qualified for: ☐ 3 months ☐ 6 months ☐ 1 year ☐ other (specify): \_\_\_\_\_
- ☐ Wearing corrective lenses ☐ Wearing hearing aid ☐ Accompanied by a waiver/exemption (specify type): \_\_\_\_\_
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate ☐ Qualified by operation of 49 CFR 391.64 (Federal)
- ☐ Driving within an exempt intracity zone (see 49 CFR 391.52) (Federal)
- ☐ Determination pending (specify reason): \_\_\_\_\_
- ☐ Return to medical exam office for follow-up on (must be 45 days or less): \_\_\_\_\_
- ☐ Medical Examination Report amended (specify reason): \_\_\_\_\_
- (if amended) Medical Examiner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_
- ☐ Incomplete examination (specify reason): \_\_\_\_\_

**If the driver meets the standards outlined in 49 CFR 391.41, then complete a Medical Examiner's Certificate as stated in 49 CFR 391.43(h), as appropriate.**

I have performed this evaluation for certification. I have personally reviewed all available records and recorded information pertaining to this evaluation, and attest that to the best of my knowledge, I believe it to be true and correct.

Medical Examiner's Signature: \_\_\_\_\_

Medical Examiner's Name (please print or type): A. Gorovits, MDMedical Examiner's Address: 550 E Boughton Rd, Suite 140 City: Bolingbrook State: IL Zip Code: 60440Medical Examiner's Telephone Number: (630) 972-0733 Date Certificate Signed: 06/29/2021Medical Examiner's State License, Certificate, or Registration Number: 036-113828 Issuing State: IL☒ MD ☐ DO ☐ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse☐ Other Practitioner (specify): \_\_\_\_\_National Registry Number: 5851616654Medical Examiner's Certificate Expiration Date: 06/29/2023



OFFICE OF THE SECRETARY OF STATE

April 10, 2021

DRIVER SERVICES DEPARTMENT

2701 SOUTH DIRKSEN PARKWAY  
SPRINGFIELD, ILLINOIS 62723

JESSE WHITE  
SECRETARY OF STATE

MIRSAD VUKOVIC  
1661A VALLEY FORGE CT  
WHEATON, IL 60189

RE: V212-5406-0013

Med. Cert. Expiration Date: 07-08-21

Dear Driver:

Our records indicate you currently hold a CDL license with medically certified status of Non-excepted interstate (NI) for transportation of interstate commerce. In order to maintain your certified NI status, you must keep all your CDL medical documents up to date with our office. These include your DOT Medical Examiner's Certificate and any applicable Waiver/Exemption or SPE. Our records indicate one of these documents is nearing expiration.

To maintain this certified interstate status, you will need to provide proof that the expiring document(s) indicated above have been renewed. Your new medical documents can be presented at any CDL facility or mailed to the address above ATTN: CDL Medical. To ensure proper processing provide the required documentation within (10) ten business days of the above expiration date. Failure to do so will result in your commercial driving privileges being reported as medically "not certified". A status of medically "not certified" indicates you no longer have the privilege of operating a commercial vehicle in interstate commerce according to 49 CFR Part 391 of the Federal Motor Carrier Safety Regulations.

**IMPORTANT NOTICE:** Effective May 21, 2014, all interstate medical certifications must be conducted by a medical provider certified through FMCSA National Registry. All interstate medical certificates issued on or after May 21, 2014 **must contain the provider's National Registry number**. For National Registry providers near you visit [nationalregistry.fmcsa.dot.gov](http://nationalregistry.fmcsa.dot.gov).

If you do not wish to maintain the certified Non-excepted Interstate (NI) status, you must change your medical declaration category or downgrade from your CDL to a non-CDL license.

To change your medical category to Excepted Interstate (EI), you can visit a CDL Drivers Facility. To change your medical category to an Intrastate category (NA or EA), you must visit a CDL Facility and add the K restriction to indicate Intrastate only driving. There is a one-time requirement to bring Proof of Legal Presence with you to the CDL facility. You may visit [cyberdriveillinois.com](http://cyberdriveillinois.com) for a list of approved CDL Proof of Legal Presence documents. If you wish to downgrade to a non-CDL, you may visit any driver services facility. A fee is required for the issuance of a corrected driver's license.

**Failure to submit your medical updates or change your medical category will result in the cancellation of your commercial driving privileges.** The cancellation will go into effect (31) thirty one days from the earliest expiration date listed above.

For further information, please submit your request to the Secretary of State, CDL/Medical Card Unit, 2701 South Dirksen Parkway, Springfield, Illinois 62723 or you may call (217) 785-3002.

**THIS LETTER IS AUTHORIZED BY THE DIRECTOR OF THE DRIVER SERVICES DEPARTMENT, OFFICE OF THE SECRETARY OF STATE**