



**Human Performance Attachment – DOT Medical Examiner's Certificate**

**Louisville, NY**

**HWY23FH005**

(2 pages)

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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:** DIAZ Baez **First Name:** Harly 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-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

**Medical Examiner's Certificate Expiration Date**  
05/17/2024

**Medical Examiner's Signature** \_\_\_\_\_ **Medical Examiner's Telephone Number** \_\_\_\_\_ **Date Certificate Signed** 05/17/2022

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

MD     Physician Assistant     Advanced Practice Nurse

DO     Chiropractor     Other Practitioner (specify) \_\_\_\_\_

**Medical Examiner's State License, Certificate, or Registration Number** 024650    **Issuing State** NY    **National Registry Number** 7870601475

**Driver's Signature** \_\_\_\_\_ **Driver's License Number** \_\_\_\_\_ **Issuing State/Province** NY

**Driver's Address**  
 Street Address: \_\_\_\_\_ City: Bronx State/Province: NY Zip Code: 10467

**CLP/CDL Applicant/Holder**  
 Yes     No

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