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

**MEDICAL EXAMINER'S CERTIFICATE**  
(for Commercial Driver Medical Certification)**CMV DRIVER CERTIFICATION**I certify that I have examined (last name) Stevenson (first name) Rollin 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 (specify type): \_\_\_\_\_
- ☐ Wearing hearing aid ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate

- ☐ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
- ☐ Qualified by operation of 49 CFR 391.64 (Federal)
- ☐ Grandfathered from State requirements (State)

Medical Examiner's Certificate Expiration Date

**03/22/2025**

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

Haynes, Cherie

(972)988-0441

03/22/2023

**Medical Examiner's Telephone Number****Date Certificate Signed**

- ☐ MD ☒ Physician Assistant ☐ Advanced Practice Nurse
- ☐ DO ☐ Chiropractor ☐ Other Practitioner (specify) \_\_\_\_\_

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

PA10757

Issuing State

**National Registry Number**

TX 7471172242

**CMV DRIVER INFORMATION****Driver's Signature****Driver's Address**

Street Address: 2030 S Forum Dr Apt 606

City: Grand Prairie

State/Province: TX

Zip Code: 75052- ☒ Yes ☐ No**Driver's License Number**

11117723

**Issuing State/Province**

TX

**CLP/CDL**

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.



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☐ 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 (specify type): \_\_\_\_\_ ☐ 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)  
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03/22/2025

**MEDICAL EXAMINER INFORMATION**

Medical Examiner's Signature

Medical Examiner's Name (please print or type)

Haynes, Cherie

Medical Examiner's Telephone Number

(972)988-0441

Date Certificate Signed

03/22/2023

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

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

PA10757

Issuing State

TX

National Registry Number

7471172242

**CMV DRIVER INFORMATION**

Driver's Signature

Driver's Address

Street Address: 2030 S Forum Dr Apt 606

City: Grand Prairie

State/Province: TX

Zip Code: 75052-

☒ Yes ☐ No

Driver's License Number

11117723

Issuing State/Province

TX

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# CMV DRIVER CERTIFICATION

I certify that I have examined \_\_\_\_\_ (last name) \_\_\_\_\_ (first name) \_\_\_\_\_ (middle name) \_\_\_\_\_ (suffix) \_\_\_\_\_ in accordance with the rules of the state of Texas.

- ☒ I have reviewed the driver's license application and the driver's record and have determined that the driver is qualified to drive the vehicle for which the license is being issued.
- ☐ I have reviewed the driver's license application and the driver's record and have determined that the driver is not qualified to drive the vehicle for which the license is being issued.

- ☐ I have reviewed the driver's license application and the driver's record and have determined that the driver is not qualified to drive the vehicle for which the license is being issued.
- ☐ I have reviewed the driver's license application and the driver's record and have determined that the driver is not qualified to drive the vehicle for which the license is being issued.

The information provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5075, with any observations embodied my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Examiner's Telephone Number \_\_\_\_\_ Date Certificate Signed \_\_\_\_\_

Medical Examiner's Name (please print or type) \_\_\_\_\_

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

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

Medical Examiner's Telephone Number \_\_\_\_\_

Medical Examiner's Name (please print or type) \_\_\_\_\_

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

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

Medical Examiner's Telephone Number \_\_\_\_\_

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Medical Examiner's Telephone Number \_\_\_\_\_

Medical Examiner's Name (please print or type) \_\_\_\_\_

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

The information provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5075, with any observations embodied my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Medical Examiner's Telephone Number \_\_\_\_\_ Date Certificate Signed \_\_\_\_\_

Medical Examiner's Name (please print or type) \_\_\_\_\_

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

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

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

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

Medical Examiner's Telephone Number \_\_\_\_\_

Medical Examiner's Name (please print or type) \_\_\_\_\_

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

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

Last Name: Stevenson First Name: Rollin DOB: 09/11/1974 Exam Date: 03/22/2023

**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 391.62) (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): Haynes, Cherie

Medical Examiner's Address: 2160 E Lamar Blvd City: Arlington State: TX Zip Code: 76006-7408

Medical Examiner's Telephone Number: (972)988-0441 Date Certificate Signed: 03/22/2023

Medical Examiner's State License, Certificate, or Registration Number: PA10757 Issuing State: TX

☐ MD ☐ DO ☒ Physician Assistant ☐ Chiropractor ☐ Advanced Practice Nurse

☐ Other Practitioner (specify): \_\_\_\_\_

National Registry Number: 7471172242

Medical Examiner's Certificate Expiration Date: 03/22/2025



Last Name: Stevenson First Name: Rollin DOB: 09/11/1974 Exam Date: 03/22/2023

**TESTING**

Pulse rate: 79 Pulse rhythm regular: ☒ Yes ☐ No Height: 5 feet 10 inches Weight: 216 pounds

Blood Pressure	Systolic	Diastolic	Urinalysis	Sp. Gr.	Protein	Blood	Sugar
Sitting	132	69	Urinalysis is required. Numerical readings must be recorded.	1.010	Negative	Negative	Negative
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.*

**Vision**

*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.*

**Hearing**

*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).*

**Acuity**      Uncorrected      Corrected      Horizontal Field of Vision

Right Eye:    20/ 25      20/             Right Eye: 130 degrees

Left Eye:     20/ 25      20/             Left Eye: 130 degrees

Both Eyes:    20/ 25      20/       

Check if hearing aid used for test: ☐ Right Ear ☐ Left Ear ☒ Neither

**Whisper Test Results**

Right Ear      Left Ear

Record distance (in feet) from driver at which a forced whispered voice can first be heard

5      5

OR

**Audiometric Test Results**

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz

Applicant can recognize and distinguish among traffic control signals and devices showing red, green, and amber colors ☒ Yes ☐ No

Monocular vision ☐ Yes ☒ No

Referred to ophthalmologist or optometrist? ☐ Yes ☒ No

Received documentation from ophthalmologist or optometrist? ☐ Yes ☒ No

Average (right):                           Average (left):                     

**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)





MEDICAL RECORD #

(or sticker)

**SECTION 1. Driver Information (to be filled out by the driver)****PERSONAL INFORMATION**

Last Name: Stevenson First Name: Rollin Middle Initial: \_\_\_\_\_ Date of Birth: 09/11/1974 Age: 48  
Street Address: 2030 S Forum Dr Apt 606 City: Grand Prairie State/Province: TX Zip Code: 75052-  
Driver's License Number: 11117723 Issuing State/Province: TX Phone: (214)334-5376  
E-mail (optional): Ops@eye1.net CLP/CDL Applicant/Holder\*: ☒ Yes ☐ No  
Driver ID Verified By\*\*: Drivers License  
Has 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

Ibuprofen, vitamin

(Attach additional sheets if necessary)

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Last Name: Stevenson First Name: Rollin DOB: 09/11/1974 Exam Date: 03/22/2023

**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 checked="" type="radio"/>	<input 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

Q29 - 1 pack a day;

(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: 3/22/2023 5:57:40 PM

**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).

Medications Comments - reviewed; Q29 - reviewed;

(Attach additional sheets if necessary)



## Additional Notes Addendum

Last Name: Stevenson First Name: Rollin DOB: 09/11/1974 Exam Date: 03/22/2023

### DRIVER HEALTH HISTORY

Surgery (continued):

Medications (continued):

Ibuprofen, vitamin

Health History Yes Answers(continued):

Q29 - 1 pack a day;

Other Health Conditions (continued):

Examiner Comments (continued):

Medications Comments - reviewed; Q29 - reviewed;

### PHYSICAL EXAMINATION

### OTHER TESTING

Glucose Meter Measurements ( mg/dl):

Neck Circumference: (Inches): 16.5

BMI: 31

Additional comments for abnormal urine values:



Last Name:	<u>Stevenson</u>	First Name:	<u>Rollin</u>	DOB:	<u>09/11/1974</u>	Exam Date:	<u>03/22/2023</u>
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<b>CERTIFICATION</b>	
Does Not Meet Standards (continued):	
<div></div>	
Monitoring required due to (continued):	
<div></div>	
Reason Text (continued):	
<div></div>	



## FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



SPECIMEN ID NO. 7930044526



OMB No. 0930-0168

## STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

<b>A. Employer Name, Address, I.D. No.</b> Concentra Arlington North Private Pay-Arlington North - 2400-13564 2160 E Lamar Blvd Arlington, TX 76006 Phone: 972-988-0441 Fax: 972-641-0054		<b>Lab Acct #: 65001388</b>	<b>B. MRO Name, Address, Phone and Fax No.</b> Michelle Alexander, M.D. 8140 Ward Parkway Kansas City, MO 64114 Phone: 888-382-2281 Fax: 913-469-4029
<b>C. Donor SSN, Employee I.D., or CDL State and No.</b> TX11117723			
<b>D. Specify Testing Authority:</b> <input type="checkbox"/> HHS <input type="checkbox"/> NRC <b>Specify DOT Agency:</b> <input checked="" type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG			
<b>E. Reason for Test:</b> <input checked="" type="checkbox"/> Pre-Employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Suspicion/Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow Up <input type="checkbox"/> Other (Specify)			
<b>F. Drug Tests to be Performed:</b> <input checked="" type="checkbox"/> THC, COC, PCP, OPI, AMP <input type="checkbox"/> THC & COC Only <input type="checkbox"/> Other (Specify)			
<b>G. Collection Site Address:</b> Concentra Arlington North - 2842 2160 E LAMAR BLVD ARLINGTON, TX 76006		<b>Collector Contact Info: Phone</b> 972-988-0441 <b>Fax</b> 972-641-0054 <b>Other</b>	<b>2642-TJ107</b> Clinic ID

## STEP 2: COMPLETED BY COLLECTOR (make remarks when appropriate).

<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID	
<b>Collection:</b> <input checked="" type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided, Enter Remark	
<b>URINE:</b> Collector reads urine temperature within 4 minutes. Temperature between 90° and 100° F? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No. Enter Remark <input type="checkbox"/> Observed, Enter Remark	
<b>ORAL FLUID:</b> Split type: <input type="checkbox"/> Serial <input type="checkbox"/> Concurrent <input type="checkbox"/> Subdivided <b>Each Device Within Expiration Date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Volume Indicator(s) Observed</b>	
<b>REMARKS:</b>	

## STEP 3: Collector affixes seal(s) to bottle(s)/tube(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5 on Copy 2 (MRO Copy)

## STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY TEST FACILITY

I certify that the specimen given to me by the donor identified in the certification section on Copy 2 of this form was collected, labeled, sealed and released to the Delivery Service noted in accordance with applicable Federal requirements.		<b>SPECIMEN BOTTLE(S)/TUBE(S) RELEASED TO:</b>  <b>FEDEX</b> Name of Delivery Service
<b>X</b> Signature of Collector Stephanie Vargas (PRINT) Collector's Name (First, MI, Last)	Date (Mo./Day/Yr.) 03 / 22 / 2023 Time of Collection 12:53:16	<input type="checkbox"/> AM <input checked="" type="checkbox"/> PM

## STEP 5: COMPLETED BY DONOR

I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct.			
<b>X</b> Signature of Donor	Rollin Jerome Stevenson (PRINT) Donor's Name (First, MI, Last)	Date (Mo./Day/Yr.) 03 / 22 / 2023	Date (Mo./Day/Yr.) 09 / 11 / 1974
Email	Day Phone (214) 334-5376	Evening Phone ( ) Not Provided	Date of Birth
After the Medical Review Officer receives the test results for the specimen identified by this form, he/she may contact you to ask about prescriptions and over-the-counter medications you may have taken. Therefore, you may want to make a list of those medications for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a separate piece of paper or on the back of your copy (Copy 5). - DO NOT PROVIDE THIS INFORMATION ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU.			

## STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

<input checked="" type="checkbox"/> URINE <input type="checkbox"/> ORAL FLUID	
In accordance with applicable Federal requirements, my verification is:	
<input type="checkbox"/> Negative <input type="checkbox"/> Positive for:	
<input type="checkbox"/> Dilute	
<input type="checkbox"/> Refusal to Test because - check reason(s) below:	
<input type="checkbox"/> ADULTERATED (adulterant/reason):	
<input type="checkbox"/> SUBSTITUTED	
<input type="checkbox"/> OTHER:	
<b>REMARKS:</b>	
<b>X</b> Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)

## STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

In accordance with applicable Federal requirements, my verification for the split specimen (if tested) is:	
<input type="checkbox"/> RECONFIRMED for:	
<input type="checkbox"/> FAILED TO RECONFIRM for:	
<b>REMARKS:</b>	
<b>X</b> Signature of Medical Review Officer	(PRINT) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.)





STEVEN C. McCRAW  
DIRECTOR  
FREEMAN F. MARTIN  
DWIGHT D. MATHIS  
JEFF WILLIAMS  
DEPUTY DIRECTORS

# TEXAS DEPARTMENT OF PUBLIC SAFETY

5805 N LAMAR BLVD • BOX 4087 • AUSTIN, TEXAS 78773-0001

[www.dps.texas.gov](http://www.dps.texas.gov)  
DRIVER LICENSE DIVISION  
512-424-2600  
EN ESPANOL 512-424-7181



COMMISSION  
STEVEN P. MACH, CHAIRMAN  
NELDA L. BLAIR  
STEVE H. STODGHILL  
DALE WAINWRIGHT

01/28/2023

STEVENSON, ROLLIN  
1861 BROWN BLVD#217-669  
ARLINGTON, TX 76006

243.0039.01.A

DL No: 11117723

## Commercial Driver License Medical Certification Renewal Notice

Our records indicate the medical information you have on file will soon expire.

Medical Certificate Expiration Date: 03/29/2023

All commercial drivers are required to provide the department with the appropriate application form(s) certifying to the type of commercial motor vehicle they drive or expect to drive. Commercial drivers who operate in certain types of commerce are also required to provide a current medical examiner's certificate and any variances or waivers they may have in order to maintain their commercial driver license (CDL) and/or commercial learners permit (CLP) driver eligibility.

The Self-Certification Affidavit you provided indicates you are required to maintain a current medical examiner's certificate for the operation of a commercial motor vehicle. Therefore you must submit an updated copy of your medical examiner's certificate or variance to the Department. Failure to submit this updated certificate or medical variance information will result in your medical certificate status being updated to not-certified and your license being downgraded to a non-commercial driver license, and/or your CLP will no longer be in good standing. **Once downgraded, you will be required to complete all applicable knowledge and driving tests to reinstate your CDL and/or CLP.**

Please email, fax, or mail the medical certificate/variance information to:

**Email** (pdf format only): [CDLMedCert@dps.texas.gov](mailto:CDLMedCert@dps.texas.gov)  
**Mail:** Texas Department of Public Safety  
Enforcement & Compliance Service Attention: CDL Section  
P.O. Box 4087  
Austin, Texas 78773-0320

**Fax:** 512-424-2002

If you have any questions, additional information on this requirement may be found at [www.fmcsa.dot.gov/registration-licensing/cdl/faqs.aspx#question1](http://www.fmcsa.dot.gov/registration-licensing/cdl/faqs.aspx#question1), or call us at (512) 424-2600.

### Additional Reminders

If you are not a registered voter, a voter registration application can be completed in any driver license office.

Any license holder who is delinquent on child support payments must contact The Attorney General of Texas to make satisfactory arrangements. Failure to do so may result in the suspension, revocation or denied issuance of the holder's driver license.

**Website:** [www.oag.state.tx.us](http://www.oag.state.tx.us)

**Email:** [child.support@oag.texas.gov](mailto:child.support@oag.texas.gov)

**Mailing Address:** The Attorney General of Texas  
Child Support Division  
PO Box 12017  
Austin, Texas 78711-2017

**Phone:** (800) 252-8014 or (800) 572-2686 (for hearing impaired)



**Concentra Medical Centers**

2160 E Lamar Blvd ARLINGTON, TX 76006  
Phone: (972) 988-0441 Fax: (972) 841-0054

**Date:** 03/22/2023**Payment Receipt - Admission****Patient:** Stevenson, Rollin T.**Employer:** Private Pay-Arlington Nor

<b>Service Date</b>	<b>Service Performed</b>	<b>Payor Acct.</b>	<b>Qty.</b>	<b>Price</b>	<b>Extended Price</b>
03/22/2023	DOT Physical		1	\$130.00	\$130.00
03/22/2023	Regulated UDS 65304		1	\$95.00	\$95.00
<b>Subtotal:</b>					\$225.00
<b>Tax:</b>					\$0.00
<b>Amount Due:</b>					\$225.00
<b>Amount Collected:</b>					\$225.00
Received by capeloax					
<b>Balance Due:</b>					<u>\$0.00</u>

**Case Acct.:** 27300736**Please retain this receipt as your record of payment**