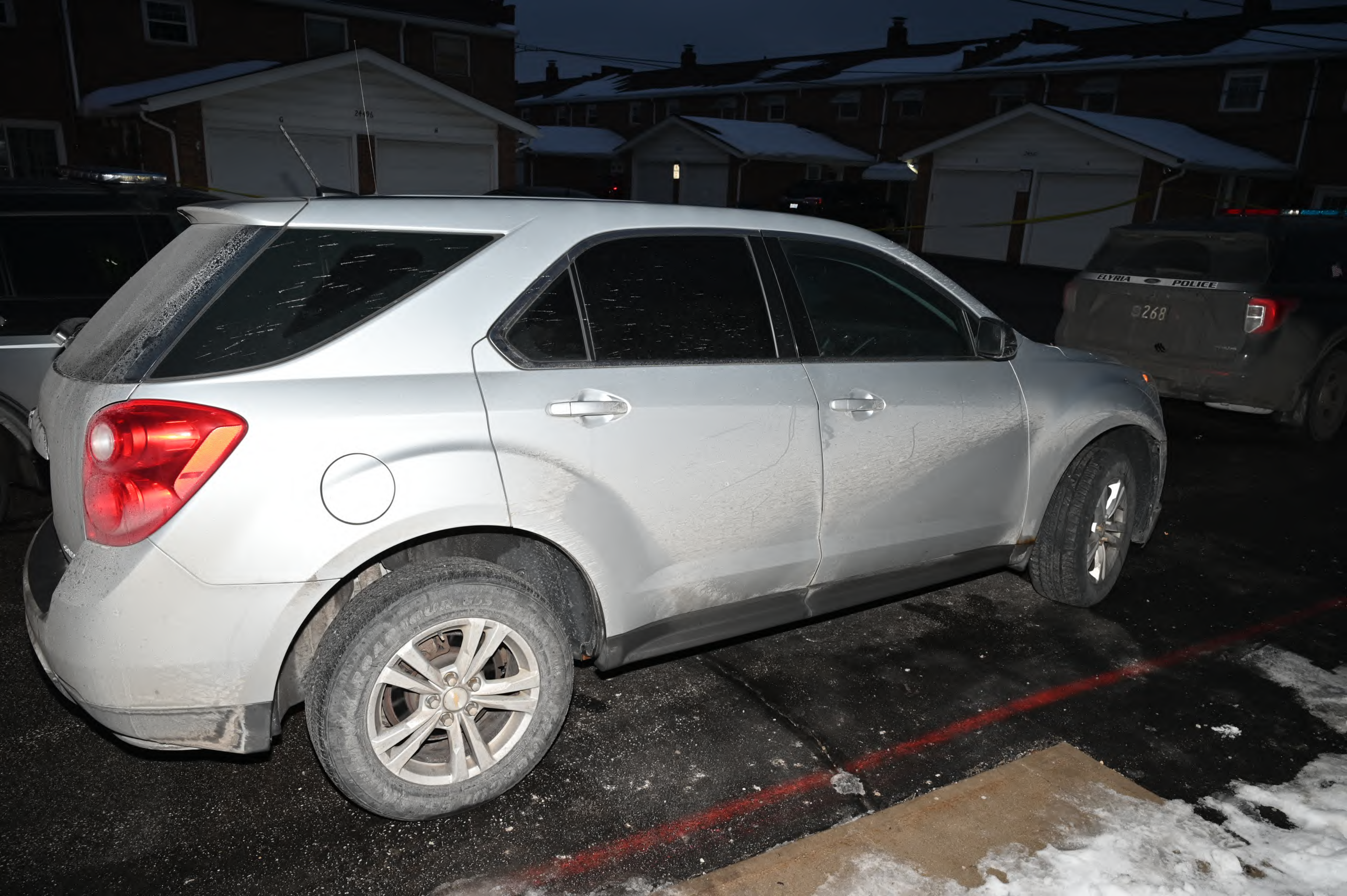
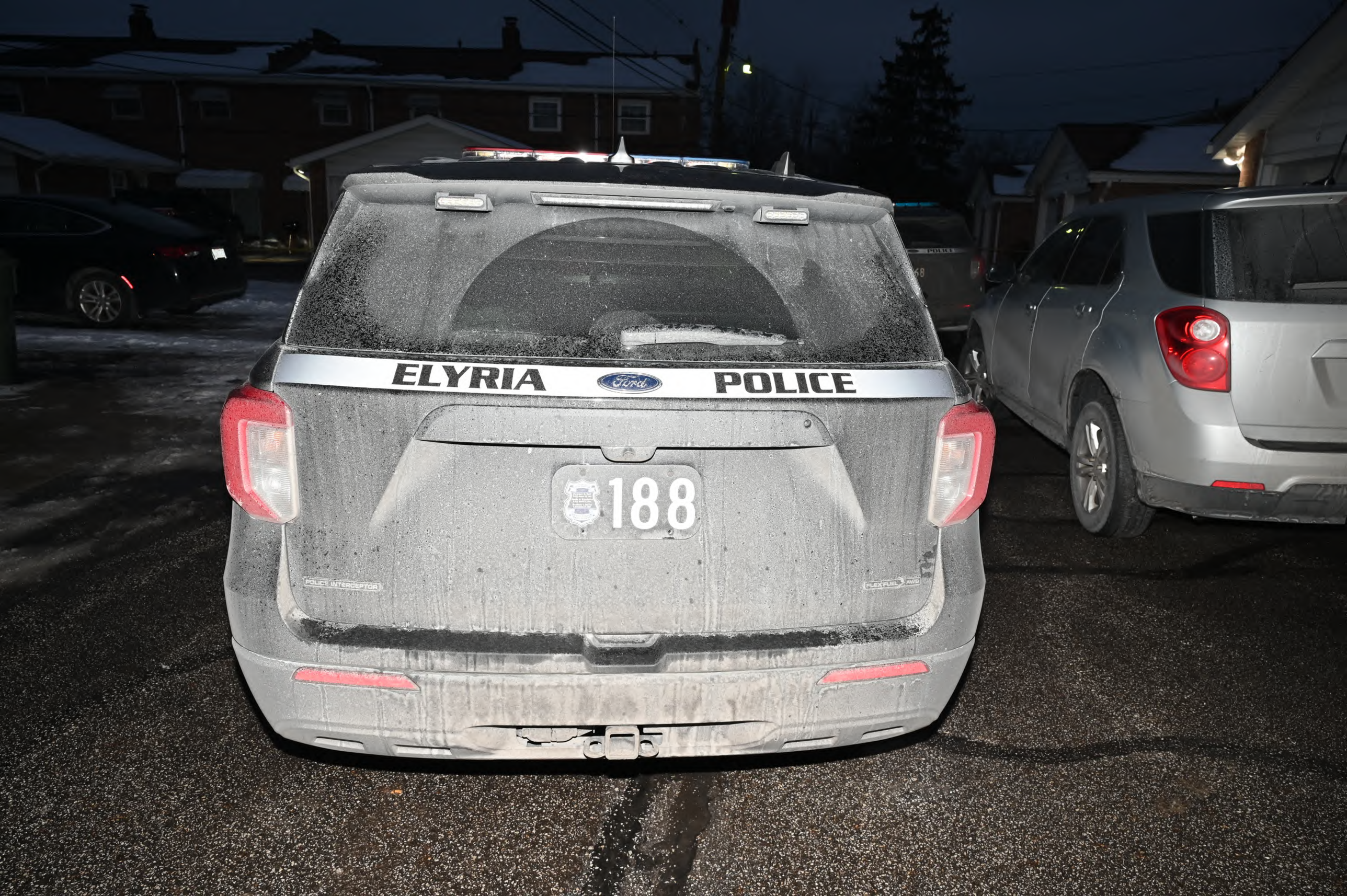

ELYRIA POLICE
268


ELYRIA
POLICE
188
POLICE INTERCEPTOR
FLEX FUEL
AWD

VERIFY PRESENCE OF ODH WATERMARK HOLD TO LIGHT TO VIEW

STATE OF OHIO
OFFICE OF VITAL STATISTICS

CERTIFICATION OF BIRTH

STATE FILE NUMBER	1989006709	DATE RECORD FILED	02/14/1989
NAME	JOHN PAUL JOHNSON		
DATE OF BIRTH	01/09/1989	SEX	MALE
BIRTHPLACE	OHIO		
MOTHER'S NAME	PATRICIA ANN JOHNSON	FATHER'S NAME	
LAST NAME PRIOR TO FIRST MARRIAGE	JOHNSON		
MOTHER'S BIRTHPLACE	OHIO	FATHER'S BIRTHPLACE	

Note:

This is a true certification of the name and birth facts as recorded in the Office of Vital Statistics, Columbus, Ohio. Witness my signature and seal of the Department of Health this 28 day of June, 2023

Rena M. Baker

State Registrar of Vital Statistics

H10531164

LORAIN CO GENERAL HEALTH DIST

REV. 7/2015

VOID WITHOUT WATERMARK OR IF ALTERED OR ERASED

VERIFY PRESENCE OF ODH WATERMARK HOLD TO LIGHT TO VIEW

SOCIAL SECURITY

[redacted]

THIS NUMBER HAS BEEN ESTABLISHED FOR

JOHN PAUL JOHNSON

SIGNATURE

I certify that I have examined **Last Name:** JOHNSON **First Name:** JOHN 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 ☐ 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
03/04/2026

Medical Examiner's Signature

Medical Examiner's Name *(please print or type)*
Paul Nikolic

Medical Examiner's State License, Certificate, or Registration Number
[redacted]

Medical Examiner's Telephone Number
(440) [redacted]

Date Certificate Signed
03/04/2024

( ) Physician Assistant ( ) Advanced Practice Nurse

( ) Other Practitioner *(specify)* _____

National Registry Number
9568036360

Driver's Signature

Driver's Address
Street 1224 EUCLID AVE City LORAIN State OH Zip Code 44052

Issuing State/Province
Ohio

CLP/CDL Applicant/Holder
( ) Yes (●) No

I certify that I have examined **Last Name:** JOHNSON **First Name:** JOHN 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
- [ ] Wearing hearing aid
- [ ] Accompanied by a _____ waiver/exemption
- [ ] Accompanied by a Skill Performance Evaluation (SPE) Certificate
- [ ] Driving within an exempt intracity zone (49 CFR 391.62) *(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
03/04/2026

Medical Examiner's Signature

Medical Examiner's Telephone Number
(440) 329-7490

Date Certificate Signed
03/04/2024

Medical Examiner's Name *(please print or type)*
Paul Miotto

(•) MD ( ) Physician Assistant ( ) Advanced Practice Nurse
( ) DO ( ) Chiropractor ( ) Other Practitioner *(specify)* _____

Medical Examiner's State License, Certificate, or Registration Number
35061718

Issuing State
Ohio

National Registry Number
9568036360

Driver's Signature

Driver's License Number
[redacted]

Issuing State/Province
Ohio

Driver's Address
Street Address: 1224 EUCLID AVE City: LORAIN State/Province: OH Zip Code 44052

CLP/CDL Applicant/Holder
( ) Yes (•) No