THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF PUBLIC UTILITIES

Transportation Oversight Division
One South Station – Boston, MA 02110
(617) 305-3559

Medical Evaluation Form
For School Bus Operator Certificates

I hereby authorize the physician completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Department of Public Utilities.

____ __________________
Applicant's Signature Date

Patient Information: Name____________________________________ DOB__________________

Lic. #____________________________________ End.__________________

This form must be <u>FULLY COMPLETED</u> by a physician (a <u>MEDICAL DOCTOR</u> who is licensed to practice in the Commonwealth of Massachusetts).

1. **Distant Visual Acuity (Snellen):** Left eye: (OS) 20/____ Right eye: (OD) 20/____
Does the applicant use corrective lenses for driving? Yes___ No___
(If the applicant uses corrective lenses for driving, please specify visual acuity above as corrected with Rx).
Combined horizontal peripheral field of vision (record in degrees): ____________
Is the applicant able to distinguish the colors red, green, and amber? Yes___ No___

2. **Hearing:** Left ear:_______ Right ear:_______
Does the applicant use a hearing aid? Yes___ No___

3. Does the applicant have a **respiratory disease/disorder**? Yes___ No___
Does the applicant use supplemental oxygen? Yes___ No___
Please indicate the applicant's oxygen saturation rate (with supplemental oxygen if used):_______
Additional comments: ____
____

4. Is the applicant currently diagnosed as having **diabetes mellitus**? Yes___ No___
If so, (1) has the applicant ever had a hypoglycemic episode or spell? Yes___ No___
And, (2) is the applicant **insulin dependant**? Yes___ No___
Additional comments: ____
____

5. Is the applicant currently diagnosed as having **Epilepsy**? Yes___ No___
Has the applicant ever had a **seizure** or other type of **altered/loss of consciousness**?
Yes___ No___
If so, please explain and state type and date of last episode: ________________________________
____
Additional comments:____

6. Does the applicant have a **cardiovascular condition**? Yes___ No___
If so, (1) does the applicant have an implanted cardiac defibrillator? Yes___ No___
(2) does the applicant have AHA functional Class III or IV heart disease?
Yes___ No___
(3) specify AHA functional class and symptoms: ____________________________________
____
Additional Comments: ____
____

7. Does the applicant have a **loss of foot, leg, hand, or arm** likely to interfere with safe driving?
Yes___ No___
Does the applicant have an **impairment of use of foot, leg, fingers, hand, or arm** likely to interfere with safe driving? Yes___ No___
Does the applicant have any **other physical condition or limitation** likely to interfere with safe driving? Yes___ No___
If so, please describe the patient's medical condition: ____________________________________
____
Also, please describe the extent, frequency, and control of the symptoms of the patient's condition or disability which may affect his/her ability to operate a school bus:________________________
____

8. Is the patient on any **medication(s)**? Yes___ No___
If so, please list medication(s) with dosage(s):____
____
Are these medications, separately or combined, likely to interfere with the ability to operate a school bus safely ? Yes___ No___

9. Has the applicant for or obtained a RMV issued Disability Placard/Plate? Yes___ No___

10. Please check one of the following categories:
I hereby certify that in my professional opinion and to a reasonable degree of medical certainty
___ that the patient named above **IS** medically qualified to operate a school bus safely.
___ that the patient named above **IS NOT** medically qualified to operate a school bus safely.

Additional comments: ____
____
____
____

Physician's Name: ____________________________________ Registration #: ____________________

Street Address: _______________________________________ City: ____________________________

Signature: ____ Date: ____________________________