**Washington State Authorized School Bus Driver**



**Diabetes Exemption Program**

**Licensed Physician Evaluation Section**

**Driver Information**

Last Name: First Name: MI:

Address:

City: State: ZIP code:

DOB (MM/DD/YYYY): \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_

This individual is applying for a Washington State school bus driver diabetes exemption to be able to take insulin while operating a school bus in Washington State. Part of the application process is an evaluation by a licensed physician to determine if the individual has any medical problems related to diabetes that might impair safe driving.

PLEASE CHECK/FILL IN REQUESTED INFORMATION.

1. I am a licensed physician. [ ]

**If not, do not continue your assessment.** Applicants must be evaluated by a licensed physician.

1. Office telephone number: (\_\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_
2. Office fax number: (\_\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_
3. Date of examination (MM/DD/YYYY): \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_
4. I am familiar with the patient’s medical history for the past five years through a records review, treating the patient, or consultation with the treating physician.

(check one) YES [ ]  NO [ ]

A review of the applicant’s five-year medical history is required. If the history is not available, please state the reason.

Driver’s Last Name:       Driver’s First Name:

1. Date of initial diagnosis of diabetes mellitus:

Treatment for diabetes mellitus prior to insulin use:

 None [ ]  Diet [ ]  Oral agent [ ]

1. Insulin Usage:

Date insulin use began:

Type of insulin(s) and current dosage now used:

If patient uses insulin pump, current average daily dose:

Length of time on current dose:

1. Please use the Federal Motor Carrier Safety Administration’s (FMCSA) definition of a severe hypoglycemic reaction, as one that results in:

Seizure, or

Loss of consciousness, or

Requiring assistance of another person, or

Period of impaired cognitive function that occurred without warning.

In the last five years, while being treated for diabetes, has the patient had recurrent (two or more) severe hypoglycemic episodes? YES [ ]  NO [ ]

In the last 12 months, while being treated for diabetes, has the patient had a severe hypoglycemic episode? YES [ ]  NO [ ]  (If no, proceed to #9 below)

If yes, provide information on each hypoglycemic episode:

Date(s):

Include additional information about each episode including symptoms of hypoglycemic reaction, treatment, and suspected cause:

Was the patient hospitalized? YES [ ]  NO [ ]

If yes, provide brief summary of hospitalization:

Has the patient’s treatment regimen changed since the last hypoglycemic episode?

 YES [ ]  NO [ ]

Briefly explain changes:

Driver’s Last Name:       Driver’s First Name:

1. Additional Information or History (If none, write *none*.):

1. List all medications including those taken related to the treatment of diabetes:

Name of Medication Dose Reason for Taking the Medication

1. In your medical opinion, does any one of the listed medications have the potential to compromise the driver’s ability to operate a school bus safely? YES [ ]  NO [ ]

If yes, which medication(s):

1. Associated Medical Conditions (please check *yes* or *no*):

Renal Disease Renal insufficiency YES [ ]  NO [ ]

 Proteinuria YES [ ]  NO [ ]

 Nephrotic Syndrome YES [ ]  NO [ ]

Cardiovascular Coronary artery disease YES [ ]  NO [ ]

Disease Hypertension YES [ ]  NO [ ]

 Transient ischemic attack YES [ ]  NO [ ]

 Stroke YES [ ]  NO [ ]

 Peripheral vascular disease YES [ ]  NO [ ]

Neurological Disease Autonomic neuropathy YES [ ]  NO [ ]

 (i.e., cardiovascular GI, GU)

 Peripheral Neuropathy YES [ ]  NO [ ]

 (Circle below)

Sensory

Decreased sensation

Loss of vibratory sense

Loss of position sense

If the applicant has been or is currently being treated for any of the above medical conditions, provide relevant additional information (consultation notes, special studies, follow-up reports, and hospital records)**.**

Driver’s Last Name:       Driver’s First Name:

1. Laboratory Reports/Stable Insulin Regimen:
	1. Background and criteria:

The individual should have stable control and no risk of hypoglycemia and hyperglycemia while operating a school bus.

**30 day requirement:** An individual diagnosed with diabetes mellitus who had been previously treated with oral medication, and who now requires insulin, should have at least a one-month period on insulin to establish stable control.

**60 day requirement:** An individual newly diagnosed with diabetes mellitus, who is now starting insulin, should have at least a two-month period on insulin to establish stable control.

Does this individual meet the appropriate waiting period required after initial insulin treatment?

YES [ ]  NO [ ]

If no, when will driver complete the waiting period? Date:

* 1. Glycosylated hemoglobin A1c (A1c test) and blood glucose:

Review of A1c test and blood glucose testing provides evidence of the driver’s ability to manage his/her diabetes mellitus and drive safely. Newly diagnosed and treated drivers are required to provide an A1c test within 30 days of the initial date of application (and after the 60 day requirement in 13 (A) is met). Drivers with a long-term history must provide an A1c test every six months.

Please provide a copy of the following: Laboratory reports reflecting A1c test result(s), to include lab reference normal range.

Do the results of the HbA1c indicate values **less than 6.0 or greater than 9.5**?

YES [ ]  NO [ ]

If yes, in your medical opinion, was the event incidental and not an indication of failure to control glucose levels?

YES [ ]  NO [ ]

1. Glucose Measurements (a driver should not have large fluctuations in blood glucose levels):
	1. I have reviewed the patient’s daily glucose monitoring logs while using insulin.

YES [ ]  NO [ ]

* 1. Does the patient have any large fluctuations that may impact safe driving?

YES [ ]  NO [ ]

Driver’s Last Name:       Driver’s First Name:

**Note: The applicant must participate in a diabetes education program at least every three years to apply for and remain in the diabetes exemption program.**

15. Since beginning insulin use, has the patient received education in the management of diabetes that includes diet, monitoring, recognition and treatment of hypoglycemia and hyperglycemia? YES [ ]  NO [ ]

If yes, please provide last education date (MM/YYYY): \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

1. I hereby certify that in my medical opinion, the applicant understands how to individually manage and monitor his/her diabetes mellitus. YES [ ]  NO [ ]
2. I hereby certify that in my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage his/her diabetes mellitus. YES [ ]  NO [ ]
3. I hereby certify that in my medical opinion, the applicant’s medical condition allows them to safely operate a school bus, while using insulin for the control of diabetes mellitus. YES [ ]  NO [ ]
4. The following restrictions/conditions apply:

1. Licensed Physician’s Identification:

(please print)

Last name: First Name:

Medical license number: State of issue:

Signature: Date:

 (Part B is valid for 24 months from the date the physician signs this form.)