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| OSPI Logo |  OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION PUPIL TRANSPORTATION Old Capitol Building PO BOX 47200  Olympia WA 98504-7200 **WASHINGTON STATE AUTHORIZED SCHOOL BUS DRIVER** **DIABETES EXEMPTION PROGRAM**  |

1. **Driver Information**

Last Name:       First Name:       MI:

Address:

City:       State:       ZIP code:

Telephone number: (     )       -

Employee or identification number (if required by Employer):

1. **School District or Employer’s Name:**
2. **Driver License and Motor Vehicle Record**

Please attach a readable copy of your current, valid Washington State Driver’s License indicating an Intrastate Medical Waiver for Diabetes **or** a valid interstate exemption certificate for diabetes issued by the Federal Motor Carrier Safety Administration (FMCSA).

1. **Acknowledgement of Responsibility**

I acknowledge that I have read and understand the requirements for an insulin treated diabetic to maintain a Washington State school bus driver authorization as contained in WAC 392-144-020(9). In particular, I must

1. Possess a valid commercial driver license intrastate medical waiver for diabetes from the Washington State Department of Licensing (DOL) or a valid interstate exemption certificate for diabetes issued by the FMCSA. I understand that I must continue to maintain either the DOL waiver or the FMCSA exemption certificate.
2. Submit to the authorizing school district(s) or employer a copy of this form completed within the required timelines for the respective sections.
3. Continue to self-monitor blood glucose and demonstrate conformance with requirements (more than 100mg/dl and less than 300 mg/dl) within one hour before duty transporting students and approximately every four hours while on duty, using an FDA approved device.
4. Maintain a daily log of all blood glucose test results for the previous six-month period and provide copies to the authorizing school district(s) or employer, the examining licensed physician, and the Office of Superintendent of Public Instruction upon request.

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

1. Carry a source of readily absorbable/fast-acting glucose while on duty.
2. Submit to the authorizing school district(s) or employer, every six months, the results of the HbA1c test indicating values more than 5.9 and less than 9.6 (unless the medical examiner or licensed physician indicates the event was incidental and not an indication of failure to control glucose levels, using the appropriate section of this form).
3. Submit to the authorizing school district(s) or employer, the results of an annual examination (unless required more often by an ophthalmologist or optometrist) to detect any peripheral neuropathy, unstable diabetic retinopathy or clinically significant eye disease that prevents me from meeting medical certificate vision standards, or circulatory insufficiency (using the appropriate section of this form).
4. Provide a signed statement by my examining licensed physician indicating that within the past three years I have completed instructions to address diabetes management and driving safety, signs and symptoms of hypoglycemia and hyperglycemia, and what procedures must be followed if complications arise.
5. Report immediately to my employer, any failure to meet the specific glucose level requirements as listed in (3) and (6) of this application, or any loss of consciousness or control.

I understand that if I have a loss of consciousness or loss of control (cognitive function) due to a diabetic event, I do not qualify for a school bus driver authorization for one year, provided I have not had a recurrent hypoglycemic reaction requiring the assistance of another person within the previous five years. Specifically, I understand that I must remove myself from driving duties for any of the following:

* 1. Results of an HbA1c test indicating values less than 6.0 or greater than 9.5 unless accompanied by the required medical opinion that the event was incidental and not an indication of failure to control glucose levels.
	2. Results of self-monitoring indicate glucose levels less than 100 mg/dl or greater than 300 mg/dl, until self-monitoring indicates compliance with specifications.
	3. Experiencing a loss of consciousness or control relating to diabetic condition.
	4. Failing to maintain the required records.

I understand that falsification of records may result in permanent revocation of my school bus driver authorization.

I acknowledge and agree that it is my responsibility to comply with all the self-monitoring, medical testing, and reporting requirements. I accept this responsibility in order to ensure the safety of the students I will be transporting.

**Signature:**  **Date:**

 (Part A is valid for 24 months

 from the date the driver signs

 this form.