Bus Driver's Diabetic Follow-up Form

NYS DMV Commissioner's Regulation Part 6.10

(Follow-up exam is required every six months for bus drivers with diabetic conditions. Follow-up exam must be conducted by and signed by the driver's personal physician)

Bus Driver's Name: _____

(Name must correspond to name on driver's license)

Bus Driver's Date of Birth: _____ Bus Driver's Social Security #: _____

"I _____ am acting as the bus driver's personal physician. He/She is under my
(Print Physician Name)
care and treatment for an existing diabetic condition. His/Her condition is stabilized by (indicate which):

❑ Diet:

_____

_____

❑ Medication (define):

_____

_____

❑ Other means (explain):

_____

_____

I certify that he/she has not had an incident of hypoglycemic or hyperglycemic shock since the last exam."

Date exam conducted by physician: _____

Physician signature (physician must sign): _____

Physician name (print or stamp): _____

Physician address:

_____

_____

IMPORTANT:

Completed follow-up form MUST be attached to physician's letterhead or voided prescription form

PTSI Pupil Transportation Safety Institute

Moving School Transportation from Safe to Safer