

**Washington State Authorized School Bus Driver**

**Diabetes Exemption Program**

**Instructions**

Please follow these instructions to meet the School Bus Driver Diabetic Exemption Program.

There are two steps a driver will need to complete. The first step addresses the requirements associated with his/her commercial driver license (CDL) issued by the Department of Licensing (DOL), and the second step outlines the requirements associated with his/her school bus driver authorization issued by the Office of Superintendent of Public Instruction (OSPI).

1. Pursuant to *WAC 392-144-020(9)(d)(i), School bus drivers must possess a valid commercial driver license intrastate medical waiver for diabetes from Washington State Department of Licensing or a valid interstate exemption certificate for diabetes issued by the Federal Motor Carrier Safety Administration.*

To apply for an intrastate medical waiver with Washington State Department of Licensing, please follow these instructions.

1. Have your certified medical examiner complete the following forms:
   1. [Medical Examination Report](https://www.fmcsa.dot.gov/regulations/medical/medical-examination-report-form-commercial-driver-medical-certification)
   2. [Medical Examiner's Certificate](https://www.fmcsa.dot.gov/regulations/medical/medical-examiners-certificate-commercial-driver-medical-certification)
   3. [Commercial Driver License Intrastate Medical Waiver Application](http://www.dol.wa.gov/forms/520066.pdf) listing all disqualifying medical conditions and medications.
2. Submit the completed Medical Examination Report, Medical Examiner’s Certificate and Commercial Driver License Intrastate Medical Waiver Application forms to:
   1. Email: [CDLMED@dol.wa.gov](mailto:CDLMED@dol.wa.gov) (only for submitting CDL medical forms, we don't answer questions.)
   2. Mail:

CDL Medical Unit

Department of Licensing

PO Box 9030

Olympia, WA 98507-9030

1. DOL will get back to you by mail, to the address they have on record, within 2 weeks.
2. When your waiver application is approved, DOL will mail you a Certificate. You will need to visit your local licensing office and show them your certificate. DOL will issue you a new license adding the “V” restriction. There will be a $10 fee to get your license revised.

To apply for a federal medical exemption, please visit [Driver Exemption Programs](https://www.fmcsa.dot.gov/medical/driver-medical-requirements/medical-applications-and-forms) (fmcsa.dot.gov) for a diabetes package and instructions.

1. For the school bus driver authorization, the driver needs to complete a Washington State Authorized School Bus Driver Diabetes Exemption Program; Form SPI 1643 (Parts A–D). SPI Form 1643 is maintained at the school district. It is not mailed to OSPI.
2. Part A is completed by the driver. Updated at a minimum, every twenty-four (24) months.
3. Part B is completed by a licensed physician to determine if the individual has any medical problems related to diabetes that might impair safe driving. Updated at a minimum, every twenty-four (24) months.
4. Part C is completed by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving. Updated at a minimum, every twelve (12) months
5. Part D is completed by a licensed physician or medical examiner verifying the results of a Glycosylated hemoglobin A1c (A1c test). Updated at a minimum, every six (6) months.

**Note**: Parts A–D are personal medical records. SPI Form 1643 should be kept in the district’s personnel office, but separate from the driver’s personnel records. SPI Form 1643 should not be in the transportation office’s training record files. All medical records are required to be in a secure location, separate from the personnel file.

The designated district employee will enter the dates from Parts A–D to the driver’s online application and/or record and these dates will be considered verification to OSPI that the driver is in compliance with WAC 392-144-144-020(9)(d).

If you have additional questions regarding the forms, the process, or the driver’s application, please contact Kim Kimbler, Administrative Program Specialist for Student Transportation, at 360-725-6123.

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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.)

**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.)

**Washington State Authorized School Bus Driver**



**Diabetes Exemption Program**

**Vision Evaluation Section**

**Driver Information**

Last Name: First Name: MI:

Address:

City: State: ZIP code:

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

This individual is applying for an original or continuing to maintain 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 eye examination (required on an annual basis) by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving. **Note: If the applicant has retinopathy, an ophthalmologist examination is required.**

PLEASE CHECK/FILL IN REQUESTED INFORMATION.

1. I am an ophthalmologist  I am an optometrist
2. Date of most recent examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Distant visual acuity (please provide both if applicable):

UNCORRECTED  CORRECTED

Glasses

Contact Lens

Right eye: 20/\_\_\_\_\_ 20/\_\_\_\_\_

Left eye: 20/\_\_\_\_\_ 20/\_\_\_\_\_

1. Field of vision (FOV)\*:

Right eye: \_\_\_\_\_\_\_\_\_\_\_degrees (a quantitative evaluation is required)

Left eye: \_\_\_\_\_\_\_\_\_\_\_degrees (a quantitative evaluation is required)

Test used to determine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Note: If the patient has received laser treatment, and in your medical opinion you believe the patient’s FOV is compromised, Federal Motor Carrier Safety Administration (FMCSA) recommends formal perimetry to determine if the driver meets the FOV standard.

1. Color Vision:

Is the patient able to identify correctly the standard red, green, and amber traffic control signal colors? YES  NO

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

Note: If color testing results are inconclusive, it is discretionary whether to administer a controlled test using an actual traffic signal to determine the individual’s ability to recognize red, green, and amber.

An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).

1. Does the patient have diabetic retinopathy? YES  NO

If yes: Proliferative

Stable  Unstable

Nonproliferative

Stable  Unstable

Treatment:

Date diagnosed:

Surgery/procedures:

Requires recheck in \_\_\_\_ months

1. Does the patient have macular edema? YES  NO
2. Does the patient have cataract(s)? YES  NO
3. Does the patient have any other medical diagnosis related to vision?

YES  NO

If yes, what?

1. If yes to any of the conditions listed above, are any unstable?

YES  NO

If yes, which condition(s)?

1. In your medical opinion, is monitoring required more often than annually?

YES  NO

If yes, how often?

1. In your medical opinion, does the patient possess any vision problem that might impair safe driving?

YES  NO

If yes, please explain

1. 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

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

1. Ophthalmologist or Optometrist Identification:

(please print)

Last name: First Name:

Medical license number: State of issue:

Signature: Date:

(Part C is valid for 12 months from the date the physician signs this form.)

**Washington State Authorized School Bus Driver**



**Diabetes Exemption Program**

**HbA1c Report Section**

**Driver Information**

Last Name: First Name: MI:

Address:

City: State: ZIP code:

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

This individual is fulfilling requirements to maintain a Washington State school bus driver diabetes exemption to be able to take insulin while operating a school bus in Washington State. Washington Administrative Code (WAC) 392-144-020(9)(d)(vi) requires the driver to provide to the authorizing school district(s) or employer, medical examiner or physician signed results of a Glycosylated hemoglobin A1c (A1c test).

Review of A1c test and blood glucose testing provides evidence of the driver’s ability to manage his/her diabetes mellitus and drive safely.

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

Medical Examiner’s or Physician’s Signature:

Medical license number: State of issue:

Date of HbA1c

(Part D is valid for 6 months from the date

the doctor approves the HbA1c value.)