

**FLORIDA DEPARTMENT OF TRANSPORTATION  
MEDICAL EXAMINATION REPORT FOR BUS TRANSIT SYSTEM DRIVER**

**1. DRIVER'S INFORMATION** Driver completes this section.

Driver's Name (Last, First, Middle)		Birthdate // MM/DD/YY	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Preemployment <input type="checkbox"/> Biennial <input type="checkbox"/> Follow Up <input type="checkbox"/> Return to Duty	Date of Exam //
Address	City, State, Zip Code	Work Tel: ( ) - Home Tel: ( ) -	Driver License No.	License Class <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Other	Date Issued //	

**2. HEALTH HISTORY** Driver completes this section indicating any below described illness, medical condition, or injury that currently exists or has occurred. The medical examiner is encouraged to discuss with driver.

<b>YES NO</b> <input type="checkbox"/> Head/Brain injuries, disorders or illness <input type="checkbox"/> Seizures, epilepsy <input type="checkbox"/> medication _____ <input type="checkbox"/> Eye disorders or impaired vision (except corrective lenses) <input type="checkbox"/> Ear disorders, loss of hearing or balance <input type="checkbox"/> Heart disease or heart attack; other cardiovascular condition <input type="checkbox"/> medication _____ <input type="checkbox"/> Heart surgery (valve replacement/by pass, angioplasty, pacemaker) <input type="checkbox"/> High blood pressure <input type="checkbox"/> medication _____	<b>YES NO</b> <input type="checkbox"/> Muscular disease <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis <input type="checkbox"/> Kidney disease, dialysis <input type="checkbox"/> Liver disease <input type="checkbox"/> Digestive problems <input type="checkbox"/> Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> diet <input type="checkbox"/> pills <input type="checkbox"/> insulin <input type="checkbox"/> Nervous or psychiatric disorders, e.g., severe depression <input type="checkbox"/> medication _____	<b>YES NO</b> <input type="checkbox"/> Loss of, or altered consciousness <input type="checkbox"/> Fainting, dizziness <input type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring <input type="checkbox"/> Stoke or paralysis <input type="checkbox"/> Missing or impaired hand, arm, foot, leg, finger, toe <input type="checkbox"/> Spinal injury or disease <input type="checkbox"/> Chronic low back pain <input type="checkbox"/> Regular, frequent alcohol use <input type="checkbox"/> Narcotic or habit forming drug use <input type="checkbox"/> Any illness or injury not described by this section
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For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and qualification by the Medical Examiner.

\_\_\_\_\_  
Driver's Signature

\_\_\_\_\_  
Date

Medical Examiners Comments on Health History (The medical examiner must review and discuss with the driver any "yes" answers and potential hazards of medications, including over-the-counter medications, while driving.)

**TESTING (Medical Examiner completes Section 3 through 7)**

**3. VISION** Standard. A person is qualified if that person meets the vision standard established by the State of Florida for a Class A, B, C, or D driver license, as applicable. The use of corrective lenses should be noted by the Medical Examiner.

**INSTRUCTIONS:** When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious.

**Numerical readings must be provided.**

ACUITY	UNCORRECTED	CORRECTED
Right Eye	20/	20/
Left Eye	20/	20/
Both Eyes	20/	20/

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green, and amber colors?  Yes  No

Applicant meets visual acuity requirement only when wearing:  Corrective Lenses

Monocular Vision:  Yes  No

Complete next line only if vision testing is done by an Ophthalmologist or Optometrist

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Date of Examination Name of Ophthalmologist or Optometrist (print) Tel No. License No./State of Issue Signature

**4. HEARING** Standard: a) Must first perceive forced whispered voice  $\geq$  5ft., with or without hearing aid, or b) average hearing loss in better ear  $\leq$  40dB

Check if hearing aid used for tests.  Check if hearing aid required to meet standard.

**INSTRUCTIONS:** To convert audiometric test results from ISO to ANSI, -14 dB from ISO to 500 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.

**Numerical readings must be recorded.**

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear Feet	Left Ear Feet	b) If audiometer is used, record hearing loss in decibels. (acc. To ANSI Z24.5-1951)	Right Ear 500 Hz 1000 Hz 2000 Hz Average:	Left Ear 500 Hz 1000 Hz 2000 Hz Average:
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**5. BLOOD PRESSURE EVALUATION / PULSE RATE** Numerical readings must be recorded.

Blood Pressure	Systolic	Diastolic	Driver qualified if $\leq$ 160/90 on initial exam.	Pulse Rate	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular
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On initial exam      Within 3 months      Certify

If 161 - 180 and/or 91 - 104, qualify 3 mos. only.	If $\leq$ 160 and/or 90, qualify for 1 yr. Document Rx & control the 3 <sup>rd</sup> month	Annually if acceptable BP is maintained
If $>$ 180 and/or 104, not qualified until reduced to $<$ 181/105. Then qualify for 3 mos. only.	If $\leq$ 160 and/or 90, qualify for 6 mos. Document Rx & control the 3 <sup>rd</sup> month	Biannually

Medical examiner should take at least 2 readings to confirm blood pressure.

**6. LABORATORY AND OTHER TEST FINDINGS** Numerical readings must be recorded.

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.	URINE SPECIMEN	SPGR	PROTEIN	BLOOD	SUGAR
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**Diabetes.** Pre-employment Medical Examination: If, during a pre-employment examination, it is noted that a driver applicant has a medical history or clinical diagnosis of diabetes mellitus requiring insulin for control, the person shall not be qualified to drive a bus. Biennial Medical Examination: If diabetes is noted for an existing driver at the time of his or her examination, excluding pre-employment, and the diabetic condition is stabilized or controlled by insulin, oral medication and/or diet that can be obtained while the driver is on duty, then the driver may be qualified. Notwithstanding, the driver must remain under medical supervision as determined by the medical examiner. Other Testing (Describe and record)

**7. PHYSICAL EXAMINATION** Height: \_\_\_\_ (in.) Weight: \_\_\_\_ (lbs.)

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a bus safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See Instructions To The Medical Examiner, for guidance.

BODY SYSTEM	CHECK FOR:	YES	NO	BODY SYSTEM	CHECK FOR:	YES	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	<input type="checkbox"/>	<input type="checkbox"/>	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.	<input type="checkbox"/>	<input type="checkbox"/>
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.	<input type="checkbox"/>	<input type="checkbox"/>	8. Vascular system	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.	<input type="checkbox"/>	<input type="checkbox"/>
3. Ears	Middle ear disease, occlusion of external canal, perforated eardrums	<input type="checkbox"/>	<input type="checkbox"/>	9. Genito-urinary system	Hernias.	<input type="checkbox"/>	<input type="checkbox"/>
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing	<input type="checkbox"/>	<input type="checkbox"/>	10. Extremities-Limb impaired	Loss of impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.	<input type="checkbox"/>	<input type="checkbox"/>
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker.	<input type="checkbox"/>	<input type="checkbox"/>	11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.	<input type="checkbox"/>	<input type="checkbox"/>
6. Lungs and chest, not including breast examination.	Abnormal chest wall expansion, abnormal respiratory rates, abnormal breath sounds including wheezes or alveolar rates, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or xray of chest.	<input type="checkbox"/>	<input type="checkbox"/>	12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, adnormal patellar and Babinski's reflexes, ataxia.	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

**Note certification status here and on the Medical Examination Certificate.** See Instructions to the Medical Examiner and qualification criteria for guidance.

<input type="checkbox"/> Meets standards (Re-examine in 2 years)	<input type="checkbox"/> Wearing corrective lenses
<input type="checkbox"/> Does not meet standards	<input type="checkbox"/> Wearing hearing aid
<input type="checkbox"/> Meets standards, but periodic evaluation required.	

Due to \_\_\_\_\_ driver qualified only for:  3 months  6 months  1 year  Other

Temporarily disqualified due to (condition or medication): \_\_\_\_\_

Return to medical examiner's office for follow up on: \_\_\_\_\_

Please provide a completed Medical Examination Certificate to the driver's employer in accordance with 14-90.0041.

Medical Examiner's Signature: \_\_\_\_\_

Medical Examiner's Name (print): \_\_\_\_\_

MD  DO  Physician Assistant  Advanced Registered Nurse Practitioner

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Driver may request a copy of his/her completed Medical Examination Report from the medical examiner.