MEDICAL EXAMINATION CERTIFICATE

for Bus Transit System Driver

I certify that I have examined ______________________________ in accordance with the requirements in Rule 14-90.0041, Florida Administrative Code, and referenced FDOT Form 725-030-11, and with knowledge of driving duties, I find that this person:

Note certification status here and on the medical examination form.

If applicable, only when:

☐ MEETS STANDARDS (RE-EXAMINE IN 2 YEARS)	☐ Corrective Lenses
☐ DOES NOT MEET STANDARDS	☐ Wearing hearing aid
☐ MEETS STANDARDS, BUT PERIODIC EVALUATION REQUIRED	☐ Temporarily disqualified due to:
DRIVER IS QUALIFIED ONLY FOR:	
☐ 3-MONTHS ☐ 6-MONTHS ☐ 1 YEAR ☐ OTHER	
Return to medical examiner's office for follow-up on ______________________	

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachments embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Signature:	Telephone:	Date:
	Medical Examiner's License or certificate number	
Medical Examiner's Name: (Print)	Issuing State:	
	☐ MD ☐ DO ☐ Physician Assistant ☐ Advanced Registered Nurse Practitioner	

Office Address: (Print)

CITY	COUNTY	STATE	ZIP

Name of Driver: (Print)	Driver License No.	Issuing State:
Signature of Driver:		Date: