MultiCare Centers of Occupational Medicine
BetterConnected
multicareoccmed.org
PO Box 5299 | MS 820-2-OM
Tacoma, WA 98415

INTRAstate DOT Medical Exams with Insulin Treated Diabetes Mellitus Assessment

Patient Instructions

Effective 12-04-18

Not for INTERstate drivers. A separate package is available.

Documentation Requirements

Have the appropriate document below completed and signed by your treating clinician and bring to your DOT exam appointment.

These documents may be downloaded from our website www.multicareoccmed.org, or email occmed@multicare.org

Driver Type:	**Document Required**
School Bus Drivers	OSPI Form 1643 ITDM Treating Clinician Evaluation
Other Intrastate Drivers	MultiCare OccMed INTRAstate ITDM Treating Clinician Evaluation

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.

   A. Have your certified medical examiner complete the following forms:
      a. Medical Examination Report
      b. Medical Examiner's Certificate
      c. Commercial Driver License Intrastate Medical Waiver Application listing all disqualifying medical conditions and medications.

   B. Submit the completed Medical Examination Report, Medical Examiner's Certificate and Commercial Driver License Intrastate Medical Waiver Application forms to:
      a. Email: CDLMED@dol.wa.gov (only for submitting CDL medical forms, we don't answer questions.)
      b. Mail:
         CDL Medical Unit
         Department of Licensing
         PO Box 9030
         Olympia, WA 98507-9030

   C. DOL will get back to you by mail, to the address they have on record, within 2 weeks.

D. 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 (fmcsa.dot.gov) for a diabetes package and instructions.

2. 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.

   a. Part A is completed by the driver. Updated at a minimum, every twenty-four (24) months.
   b. 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.
   c. 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
   d. 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.

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): _____

2. **School District or Employer's Name:** _____

3. **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).

4. **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: _____

(5) Carry a source of readily absorbable/fast-acting glucose while on duty.
(6) 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).
(7) 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).
(8) 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.
(9) 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.

2. Office telephone number: (_____) _____ - _____

3. Office fax number: (_____) _____ - _____

4. Date of examination (MM/DD/YYYY): _____ / _____ / _____

5. 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: _____

6. Date of initial diagnosis of diabetes mellitus: _____
   Treatment for diabetes mellitus prior to insulin use:

   None ☐ Diet ☐ Oral agent ☐

7. 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: _____

8. 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: _____

9. Additional Information or History (If none, write *none*.):

_____

_____

_____

10. List all medications including those taken related to the treatment of diabetes:

Name of Medication Dose Reason for Taking the Medication

_____

_____

_____

_____

11. 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): _____

_____

12. Associated Medical Conditions (please check *yes* or *no*):

Renal Disease	Renal insufficiency	YES ☐	NO ☐
	Proteinuria	YES ☐	NO ☐
	Nephrotic Syndrome	YES ☐	NO ☐
Cardiovascular Disease	Coronary artery disease	YES ☐	NO ☐
	Hypertension	YES ☐	NO ☐
	Transient ischemic attack	YES ☐	NO ☐
	Stroke	YES ☐	NO ☐
	Peripheral vascular disease	YES ☐	NO ☐
Neurological Disease	Autonomic neuropathy (i.e., cardiovascular GI, GU)	YES ☐	NO ☐
	Peripheral Neuropathy (Circle below)	YES ☐	NO ☐

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: _____

13. Laboratory Reports/Stable Insulin Regimen:

A. 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: _____

B. 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 ☐

14. Glucose Measurements (a driver should not have large fluctuations in blood glucose levels):

A. I have reviewed the patient's daily glucose monitoring logs while using insulin.

YES ☐ NO ☐

B. 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): _____/_____

16. I hereby certify that in my medical opinion, the applicant understands how to individually manage and monitor his/her diabetes mellitus. YES ☐ NO ☐

17. 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 ☐

18. 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 ☐

19. The following restrictions/conditions apply: _____

_____

_____

_____

20. 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/_____

4. 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.

5. 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).

6. 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

7. Does the patient have macular edema? YES ☐ NO ☐

8. Does the patient have cataract(s)? YES ☐ NO ☐

9. Does the patient have any other medical diagnosis related to vision?
   YES ☐ NO ☐
   If yes, what? _____

10. If yes to any of the conditions listed above, are any unstable?
    YES ☐ NO ☐
    If yes, which condition(s)? _____

11. In your medical opinion, is monitoring required more often than annually?
    YES ☐ NO ☐
    If yes, how often? _____

12. In your medical opinion, does the patient possess any vision problem that might impair safe driving?
    YES ☐ NO ☐

    If yes, please explain _____

    _____

13. 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: _____

14. 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.)