NEW YORK STATE | Department of Motor Vehicles

ARTICLE 19-A BUS DRIVER'S DIABETIC CERTIFICATION
NYS DMV COMMISSIONER'S REGULATION PART 6.10

NOTE: If insulin is necessary to control a diabetic condition, the driver is not qualified to operate a bus if the bus driver has an established medical history or clinical diagnosis of diabetes mellitus which has not been stabilized by insulin therapy to the degree that the driver's personal healthcare provider (physician, nurse practitioner, or physician assistant) can certify that such person has not had an incident of hyperglycemic/hypoglycemic shock for a period of two years. Where diabetes can be stabilized by a diet or hypoglycemic agent, the driver must be under adequate medical supervision and follow-up.

The certification for all drivers with diabetic conditions shall consist of certification whenever diabetes is noted on a physical, including pre-employment physicals, and every six months by the driver's personal healthcare provider. The healthcare provider must certify that the driver's condition has remained stabilized and that the driver has not had an incident of hyperglycemic/hypoglycemic shock since the last certification.

This form must be used by a motor carrier to document the required pre-employment and 6-month diabetic follow-up by the driver's personal healthcare provider.

☐ PRE-EMPLOYMENT/NEW DIAGNOSIS ☐ 6 MONTH FOLLOW UP

BUS DRIVER'S NAME: _____
(Must correspond to name on driver's license)

DATE OF BIRTH: _____ DRIVER LICENSE ID NUMBER: _____
(9- digit number on driver license)

I, _____, am acting as the above-named
(Print Personal Healthcare Provider's Name)
bus driver's personal healthcare provider. The driver is under my care and treatment for an existing diabetic condition. The driver's condition is stabilized by (indicate which):

☐ Diet
☐ Medication (identify):_____ Form of Insulin: ☐ Yes ☐ No
☐ Other means (explain): _____

☐ M.D. ☐ D.O ☐ PA (physician assistant) ☐ NP (nurse practitioner)

Professional License or Certificate Number: _____ Issuing State: _____

Address: _____

_____

Phone: _____

I certify that the driver has not had an incident of hyperglycemic or hypoglycemic shock within the last six months.

Personal Healthcare Provider's Signature: X _____
(Personal Healthcare Provider must sign)

Date _____

Reset/Clear