

Application for Initial Exemption From Insulin-Treated Diabetes Mellitus Regulations

Applicant:

Date:

The applicant identified above is subject to the provisions of 33-1509, Idaho Code, has been diagnosed with Insulin-Treated Diabetes Mellitus, and is seeking an exemption from ITDM physical examination requirements specific to driving a school bus in the State of Idaho. In considering exemptions, the Department must ensure that the issuance of diabetes exemptions will not be contrary to the public interest and that the exemption achieves an acceptable level of safety. Therefore, the Department will only consider granting exemptions to ITDM individuals who meet certain conditions and who **ANNUALLY** submit the following information and any required supporting documentation:

Must Be Jointly Submitted By Driver-Applicant and School District

Hiring School District: Contact Person:
Contractor, if Applicable: Contact Phone:
District Street Address:
District Mail Address:
District City, State and ZIP:

Number of years driving school bus: Approximate number of miles per year driving school bus:
Estimated number of miles driven per week: Estimated number of daylight driving hours per week:
Estimated number of nighttime driving hours per week:

Applicant's CDL Number: Issued: Expiration Date:

- > Copy of applicant's current commercial drivers license accompanies this application (check mark required):
- > Copy of applicant's current DMV driver record check accompanies this application (check mark required):
- > Applicant has operated a commercial motor vehicle with a diabetic condition controlled by the use of insulin while under the care of a board-certified or board-eligible endocrinologist or personal physician consulting with an endocrinologist and applicant so certifies (check mark required):
- > Applicant has had no other disqualifying physical examination conditions including diabetes related complication and applicant so certifies (check mark required):
- > Applicant has had no recurrent (two or more) hypoglycemic reactions resulting in a loss of consciousness or seizure within the past five years and applicant so certifies (check mark required):
- > Applicant has had no recurrent hypoglycemic reactions requiring the assistance of another person within the past five years or has demonstrated stability for a period of at least one year following the first hypoglycemic episode and applicant so certifies (check mark required):
- > Applicant has had no recurrent hypoglycemic reactions resulting in impaired cognitive function that occurred without warning symptoms within the past five years or has demonstrated stability for a period of at least one year following the first hypoglycemic episode and applicant so certifies (check mark required):
- > Applicant has been examined by a board-certified or board-eligible endocrinologist (may be in concert with personal physician) who has conducted a complete and comprehensive medical examination including the applicant's medical history and current status with a report in compliance to 33-1509, Idaho Code, and a signed statement from the examining endocrinologist accompanies this application and the applicant so certifies (check mark required):
- > Applicant has been examined by an ophthalmologist or optometrist and has not been diagnosed with diabetic retinopathy and meets the vision standard in accordance to 33-1509, Idaho Code, or the applicant has evidence of diabetic retinopathy but has no unstable proliferative diabetic retinopathy and a signed statement from the examining specialist accompanies this application and the applicant so certifies (check mark required):
- > Applicant understands that there are special conditions attached to the issuance of any exemption for ITDM and the applicant understands the Department will impose ongoing requirements and the applicant agrees to comply with all SDE ongoing imposed requirements (see SISBO) and the applicant so certifies (check mark required):

Save Document Prior to Submitting Electronically

Applicant Signature: Date:

District Superintendent Signature: Date:

SDE Approved **Disapproved** **ITDM Waiver and Returned to District and Applicant On:** _____

Director of Student Transportation Signature: _____ Date: _____