DL-705 (4-12)

SCHOOL BUS DRIVER CARDIOVASCULAR WAIVER FORM

PLEASE TYPE OR PRINT ALL INFORMATION IN BLUE OR BLACK INK

pennsylvania
DEPARTMENT OF TRANSPORTATION
Bureau of Driver Licensing • P.O. Box 68684 • Harrisburg, PA 17106-8684
(717) 787-6453

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD 4/13/12

Provider: For more information relating to Medical Reporting, visit http://www.dmv.state.pa.us/centers/medicalReportingCenter.shtml.

PATIENT INFORMATION (Please complete this form in its entirety)

DRIVER'S LICENSE NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	E-MAIL (if applicable)
FEET	INCHES			MONTH	DAY	YEAR		

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.	CITY	STATE	ZIP CODE

SECTION A

PLEASE COMPLETE THE FOLLOWING QUESTIONS FOR ALL PATIENTS.

1. What condition(s) does the patient have? _____
2. How long have you been treating the patient for this condition(s)? _____
3. Has the patient been asymptomatic from the disorder and the medication used to treat the disorder? ❑ Yes ❑ No
4. What medication does the patient use? _____

SECTION B

PLEASE COMPLETE THIS SECTION IF THE PATIENT HAS ANY OF THE FOLLOWING CONDITIONS:
A history of coronary artery disease, previous myocardial infarction, congenital heart defects, cardiomyopathy, pericarditis, myocarditis, atrial flutter/fibrillation or valvular heart disease, angina pectoris, coronary insufficiency, congestive heart failure, paroxysmal supraventricular arrhythmias/tachycardia, peripheral vascular disease and individuals who have undergone corrective treatment.

1. What condition listed above does the patient have? _____
2. If the patient has atrial flutter/fibrillation, is the patient on anticoagulant therapy with aspirin or coumadin? ❑ Yes ❑ No
3. The individual must complete seven (7) METS on a treadmill stress EKG test preferably following the Bruce or Balke Protocol and achieve 85% of the predicted maximal heart rate without symptoms, a drop in blood pressure during exercise, significant arrhythmias or ST segment depression or elevation greater than one millimeter from baseline. If the individual is unable to achieve 85% of the predicted maximal heart rate without symptoms, the resting EKG is abnormal, or the individual is on digitalis glycosides, then a radionuclear exercise test should be performed. The result of the exercise test should show no evidence of reversible ischemia. **(Please note: Use of a Beta Blocker does not exempt the individual from achieving a predicted maximal heart rate of 85%.) Also, individuals with certain conditions, including but not limited to left bundle branch block (LBBB), pacemaker or various orthopedic conditions that make it difficult to exercise shall complete a nuclear or echocardiographic pharmacologic stress test. The results of the stress test should show no evidence of reversible ischemia, and the left ventricular ejection fraction is 40% or greater.**
   * What date was the test performed? _____
   How many METS were completed? _____
   What percentage of the maximal predicted heart rate was achieved without symptoms? _____
   Did the test show evidence of reversible ischemia? ❑ Yes ❑ No
4. If the patient is unable to complete the Bruce or Balke Protocol, what Protocol was used? _____
   * What date was the test performed? _____
   Did the test show evidence of reversible ischemia? ❑ Yes ❑ No
5. The individual must have a left ventricular ejection fraction of 40% or greater.
   * What date was the test performed? _____
   What was the left ventricular ejection fraction percentage? _____
   How was the left ventricular ejection fraction percentage measured? _____
   Did the test show evidence of reversible ischemia? _____

* **Date of test performed may not be more than 12 months old.**

PATIENT NAME_____ DRIVER'S LICENSE NUMBER_____

SECTION C

PLEASE COMPLETE THIS SECTION IF THE PATIENT HAS A PERMANENT PACEMAKER INSERTION.

1. What date did the patient undergo pacemaker insertion?_____

2. Is the patient undergoing regular pacemaker examinations? ❑ Yes ❑ No

SECTION D

A WAIVER MAY NOT BE GRANTED FOR THE FOLLOWING CONDITIONS:

(A) Symptomatic coronary artery disease (angina), cardiomyopathy, pericarditis, myocarditis, atrial flutter/fibrillation or valvular heart disease, angina pectoris, coronary insufficiency, congestive heart failure, paroxysmal supraventricular arrhythmias/tachycardia, or peripheral vascular disease.

(B) Within two months of myocardial infarction, open heart surgery or pacemaker insertion.

(C) Implanted automatic cardioverter/defibrillators or antitachycardic device.

(D) History of ventricular tachycardia (excluding couplets and triplets), ventricular fibrillation or sudden cardiac death with successful resuscitation.

(E) History of carotid sinus hypersensitivity, sick sinus syndrome, symptomatic bradycardia, second degree heart block or third degree heart block unless a pacemaker has been inserted.

(F) Unexplained sinus tachycardia.

(G) Severe valvular heart disease.

(H) Current clinical diagnosis of severe hypertension (Stage III).

1. What condition listed above does the patient have? _____

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HEALTH CARE PROVIDER INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ _____

Heath Care Provider's Signature Date