DEPARTMENT OF PUBLIC SAFETY

118 W. CAPITOL
PIERRE, SOUTH DAKOTA 57501-2000

Driver Licensing [605] 773-6883
E-Mail Address: DPSInfo@state.sd.us
Internet Address:
HTTP://www.state.sd.us/dps/dl

Dear Applicant:

Thank you for your interest in the South Dakota Diabetes School Bus Waiver Program. The information in this letter and the accompanying materials need to be read carefully. The applicant is responsible for providing all required information. The following information is required to be submitted to the South Dakota Driver Licensing Program, 118 West Capitol Avenue, Pierre, SD 57501:

1. Intrastate South Dakota Waiver Application;
2. Signed copy of the Certifying Medical Examiner Evaluation Letter;
3. Signed copy of the Medical Examination Report (completed by the Medical Examiner);
4. Signed copy of the Medical Examiner's Certificate (completed by the Medical Examiner);
5. Endocrinologist Evaluation;
6. Vision Evaluation;

The South Dakota Department of Public Safety, Driver Licensing Program will review the information submitted and notify you of its decision within 30 days of receiving all information. There is no provision for a temporary waiver during the application and review process. Please understand the issuance of a waiver is in no way an automatic event. We must be satisfied that highway safety will not be compromised. If a waiver is issued, you must comply with its terms and conditions. Failure to do so will result in the revocation of the waiver.

Instructions for South Dakota Intrastate Diabetic School Bus Waiver

A. Medical Examiner

The applicant must be examined by a physician, physician assistant or nurse practitioner. This examination **STARTS** the waiver process. The applicant **MUST** take the Certifying Medical Examiner Evaluation letter to the appointment with the medical examiner for him/her to review prior to performing the examination. The medical examiner will have copies of the United States Department of Transportation Medical Examination Report Form and the Medical Examiner's Certificate. The applicant must meet all medical standards and guidelines, other than diabetes, in accordance with 49 CFR 391.41 (b) (1-13). The physician, physician assistant or nurse practitioner must also complete and sign the Certifying Medical Examiner Evaluation Letter.

Other than the use of insulin to treat their diabetes, any other medical problem or condition that prevents the applicant from being certified by the medical examiner must be corrected **BEFORE** the rest of this application is completed. Therefore, the endocrinologist and vision evaluations **SHOULD NOT** be completed until the medical examiner certifies the applicant. The applicant must submit copies of the completed medical examination report and medical examiner's certificate. The certificate should indicate that the driver is certified **ONLY IF** the driver has a diabetes exemption. The certificate is not valid until the diabetic waiver is obtained from the South Dakota Department of Public Safety, Driver Licensing Program.

B. Endocrinologist Evaluation

The applicant must be examined by a physician who is a board-certified or board-eligible endocrinologist. The applicant must take the Endocrinologist Evaluation form and glucose logs to the appointment. The endocrinologist must complete all parts of the form and review the patient's 5 year medical history. The applicant must submit the endocrinologist's completed evaluation form and any additional reports outlined in the evaluation form to the Driver Licensing Program.

C. Vision Evaluation

The applicant must have a vision examination by an ophthalmologist or optometrist. An applicant with **diabetic retinopathy MUST be evaluated by an ophthalmologist**. The applicant must take the Vision Evaluation form to the appointment. The ophthalmologist or optometrist must complete all parts of the form. The applicant must submit the optometrist/ophthalmologist's completed evaluation form to the Driver Licensing Program.

Please note that **ALL** medical evaluations are only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

D. Additional Applicant Information

The applicant must provide a completed Intrastate Diabetic School Bus Waiver Application. Additional medical information may be required, based on review of the information submitted. Prior to submitting the application, please review all information and make sure that each form is **completely filled out and that all required information is included.** Application review will be delayed if the information submitted is not current or if it is incomplete. Mail all information to:

South Dakota Dept of Public Safety
Driver Licensing Program
118 W. Capitol Avenue
Pierre, SD 57501

Original documents **must** be mailed to the above address.

What Happens After a Completed Application Is Submitted?

The Driver Licensing Program will review the application and notify the applicant if additional information is required or missing. Please note, as stated above, additional medical information may be required.
Once the application is complete, the Driver Licensing Program will determine applicant eligibility.

If granted, the waiver is valid for operation of a school bus within South Dakota. This does not exempt the applicant from the federal requirements imposed on drivers involved in interstate commerce.

If the Applicant Does Not Meet Eligibility Criteria

If the Driver Licensing Program determines the applicant does not meet eligibility criteria, a decision letter will be mailed directly to the applicant outlining the reason that the Driver Licensing Program is unable to grant the waiver from the Federal diabetes standard.

How Long Does the Process Take?

The applicant is responsible for submitting all required information. Upon receipt of all required information the Department will notify you of it's decision within 30 days.

What Is Required of the Driver After a Waiver Is Granted?

The waiver certificate and requirements are sent to the exempted applicant and the applicant's employer or prospective employer. The Driver Licensing Program can issue a waiver for a maximum of 2 years. The driver is required to reapply for renewal every two years, and, as with monitoring, the responsibility of reapplication rests with the driver.

Each school bus driver that is granted a waiver for insulin-treated diabetes mellitus issued by the department shall maintain the waiver in the driver's possession at all times. Any school bus driver that is granted the waiver and has a severe hypoglycemic episode forfeits the waiver and may not reapply for five years.

No person who holds a waiver may operate a school bus with students present unless the person checks his or her blood glucose level no more than thirty minutes before operating the bus. If the person operates a bus for a continuous duration that exceeds eighty-nine minutes, the person shall check his or her blood glucose level each hour and record the information. The person shall submit the information to the employer each day.

Any person who holds a waiver shall, one year after issuance, undergo a physical examination and submit to their employer a signed statement from a physician, physician's assistant, or nurse practitioner that they have completed a physical examination.

If you have questions related to the application process outlined in this document, please call 605-773-5420.

Enclosures

SOUTH DAKOTA INTRASTATE DIABETIC SCHOOL BUS WAIVER APPLICATION

1. Driver Information

Name (First, Middle Initial, Last): _____

Street Address: _____

City: _____ State: _____ ZIP code: _____

Mailing Address, if different from above:

_____

City: _____ State: _____ ZIP code: _____

Telephone number: (____) _____- _____

Mobile phone number: (____) _____- _____

Fax number: (____) _____- _____

Sex (check one): Male Female

Date of birth (MM/DD/YYYY): _____

Social Security number: _____ -_____- _____

South Dakota Driver License Number _____

2. Current or Prospective Employer (School district or private contractor)

Employer's name (If applicable): _____

Employer's address: _____

City: _____ State: _____ ZIP code: _____

Employer's telephone number: (____) _____- _____

Do you currently drive for this employer? (Check one): YES _____ NO _____

3. Statement of Qualification

Prior to signing this statement, please review the Regulatory Criteria on Physical Qualifications for Commercial Drivers.

Note: "otherwise qualified" or "hold a valid medical exemption" means that you meet the physical qualifications standards to drive a Commercial Motor Vehicle (CMV) (except for diabetes) or that you have an exemption or a skill performance evaluation certificate.

By signing below, I hereby certify that the following statement is true: "I acknowledge that I must be otherwise qualified under 49 CFR 391.41(b)(1-13) or hold a valid medical exemption before I can legally operate a school bus in South Dakota."

Signature: _____

Do you have any waivers, exemptions, or Skill Performance Evaluation certificates? (Check one)

YES _____ NO _____

If yes, list each, including date of issue, date of expiration, and identification number.

Name	Issue Date	Expiration Date	ID

The driver shall give written notification to the Driver Licensing Program if there is a change:

A. Of employment,
B. In driver tasks, that may alter the conditions of the waiver,
C. Of residence and/or phone number that would effect the communications between the driver and the Driver Licensing Program.

You must have a valid South Dakota driver license to be considered for this medical waiver.

Permission is hereby granted for the release of the medical data attached, and other medical history applicable in my case, to the South Dakota Department of Public Safety, Driver Licensing Program.

I declare and affirm, under the penalties of perjury, that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. Any false statement or concealment of any material facts subjects any license issued to immediate cancellation.

Applicant's Signature _____ Date _____

Certifying Medical Examiner Evaluation Letter
South Dakota Intrastate Diabetes School Bus Waiver Program

Driver Identifying Information

Name: _____
First MI Last

DOB (MM/DD/YYYY): _____

South Dakota Driver License Number _____

This applicant is applying for a diabetes waiver to allow insulin use while operating a school bus within South Dakota only. The driver is required to be examined by a medical examiner as part of the application process. A medical examiner is defined as a physician, physicians assistant or nurse practitioner who is licensed in South Dakota to perform these examinations. This examination will assist the Driver Licensing Program in determining that the individual is qualified for all medical standards, other than diabetes, in accordance with 49 CFR 391.41 (b).

This examination begins the waiver process. The certifying medical examiner provides the applicant with a completed U.S. Department of Transportation medical examination report and medical examiner's certificate. The applicant is responsible to submit copies of these forms with their South Dakota Intrastate Diabetes School Bus Application. The U.S. Department of Transportation form and certificate are not valid until the South Dakota Driver Licensing Program has issued a diabetic waiver. Any other medical problem or condition that prevents being certified by the medical examiner must be corrected **BEFORE** the rest of this application is completed.

IT IS THE MEDICAL EXAMINER'S RESPONSIBILITY TO DETERMINE IF THE APPLICANT MEETS ALL MEDICAL STANDARDS AND GUIDELINES, OTHER THAN DIABETES, IN ACCORDANCE WITH 49 CFR 391.41 (B) (1-13). IF THE APPLICANT PASSES THE CERTIFICATION EXCEPT FOR USING INSULIN:

Check the following on the Medical Examination Report:

- meets standards but periodic evaluation required due to **"insulin use"** driver qualified only for (check the 1 year box)
- accompanied by a South Dakota diabetes waiver

Check the following on the Medical Examiner's Certificate:

- accompanied by a South Dakota diabetes waiver
- Medical examination expiration date should be one year from the date of examination.

In compliance with South Dakota Codified Law, I certify:

(1) The applicant has no other disqualifying conditions including diabetes-related complications;

(2) The applicant has had no recurrent severe hypoglycemic episodes resulting in a loss of consciousness or any severe hypoglycemic episode within the past five years;

(3) The applicant has had no recurrent severe hypoglycemic episodes requiring the assistance of another person within the past five years;

(4) The applicant has had no recurrent severe hypoglycemic episodes resulting in impaired cognitive functioning that occurred without warning symptoms within the past five years;

(5) I have conducted a complete medical examination. The complete medical examination consisted of a comprehensive evaluation of the applicant's medical history and current status. I am including a report including the following information:

(a) The date insulin use began;

(b) Diabetes diagnosis and disease history;

(c) Hospitalization records, if any;

(d) Consultation notes for diagnostic examinations;

(e) Special studies pertaining to the diabetes;

(f) Follow-up reports;

(g) Reports of any severe hypoglycemic episode within the last five years;

(h) Two measures of glycosylated hemoglobin, the first ninety days before the last and current measure;

(i) Insulin dosages and types, diet utilized for control and any significant factors such as smoking, alcohol use, and any other medications or drugs taken; and

(j) Examinations to detect any peripheral neuropathy or circulatory insufficiency of the extremities;

The applicant is required to submit a copy of these documents along with the examination paperwork from the endocrinologist and the ophthalmologist/optometrist to be reviewed by the South Dakota Driver Licensing Program for the determination of qualification for the South Dakota Intrastate Diabetes School Bus waiver exemption.

If you have questions, please call 605-773-5420 or e-mail us at DPSLicensingInfo@state.sd.us.

Please print and sign your name below and return this to the applicant:

I declare and affirm, under the penalties of perjury, that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Medical Examiner's Signature: _____ Date: _____

Medical Examiner's Name (please print): _____

South Dakota Medical License Number: _____

Endocrinologist Evaluation
South Dakota Intrastate Diabetic School Bus Waiver Program

Driver Identifying Information

Name: _____
First MI Last

Address: _____

DOB (MM/DD/YYYY): _____

South Dakota Driver License Number _____

This applicant is applying for a South Dakota waiver to be able to take insulin while operating a school bus within the state of South Dakota. Part of the application process is an evaluation by a board-certified or board-eligible Endocrinologist to determine if the individual has any medical problem related to diabetes that might impair safe driving.

The applicant's examination by an Endocrinologist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

If you are not a board-certified or board-eligible endocrinologist, do not continue your assessment. Applicants must be evaluated by an endocrinologist who is board-certified or board-eligible.

1. Office telephone number: _____

2. Office fax number: _____

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

4. I am familiar with the patient's medical history for the past 5 years either through actual treatment or through a records review and consultation with the treating physician.

   YES _____ NO _____

   A review of the applicant's 5-year medical history is required. If the history is not available, please state the reason.

   _____
   _____
   _____

5. Date of initial diagnosis of diabetes mellitus: _____

Treatment for diabetes mellitus prior to insulin use:

None _____ Diet _____ Oral agent _____

6. 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: _____

7. 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 5 years, while being treated for diabetes, has the patient had recurrent (2 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 #8).**

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:
_____
_____
_____

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

9. List all medications including those taken related to the treatment of diabetes (if none, write none):

Name of Medication	**Dose**	**Reason for Taking the Medication**

10. 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):

_____

_____

11. 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 one 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).

12. Laboratory Reports/Stable Insulin Regimen:

A. Background and criteria:

The driver 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 1-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 2-month period on insulin to establish stable control.

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 date of application. Drivers with a long-term history must provide an A1c test within 6 months of the date of application.**

Please provide a copy of the following:
Laboratory reports reflecting A1c test result(s), to include lab reference normal range.

13. 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 _____

14. 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): _____

Note: The applicant must participate in a diabetes education program at least annually to apply for and remain in the diabetes exemption program.

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

16. In my medical opinion, the applicant has demonstrated the ability and willingness to properly monitor and manage their diabetes. YES _____ NO _____

17. I hereby certify that in my medical opinion, the applicant is able to safely operate a school bus while using insulin. YES _____ NO _____

If you have questions regarding this form, please call 605-773-5420 or e-mail us at DPSLicensingInfo@state.sd.us.

Please print and sign your name below and return this to the applicant:

I declare and affirm, under the penalties of perjury, that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Endocrinologist's Signature: _____ Date: _____

Endocrinologist's Name (please print): _____

South Dakota Medical License Number: _____

Vision Evaluation
South Dakota Intrastate Diabetes School Bus Waiver Program

Driver Identifying Information

Name: _____
First MI Last
Address:_____

DOB (MM/DD/YYYY): _____

South Dakota Driver License Number: _____

This applicant is applying for a South Dakota diabetes waiver to be able to take insulin while operating a school bus within South Dakota. Part of the application process is an eye examination 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.

The applicant's examination by an ophthalmologist or an optometrist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

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, the Driver Licensing Program 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 _____

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 _____

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

    If yes, how often? _____

I certify the applicant meets the vision standards in 49 CFR 391.41(b)(10), as amended January 1, 2009, or has been issued a valid medical exemption.

If you have questions, please call 605-773-5420 or e-mail us at DPSLicensingInfo@state.sd.us.

Please print and sign your name below and return this to the applicant:

I declare and affirm, under the penalties of perjury, that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Optometrist/Opthamologist Signature: _____ Date: _____

Optometrist/Opthamologist Name (please print): _____

South Dakota Medical License Number: _____