REGISTRY OF MOTOR VEHICLES

Medical Form for a School Pupil (7D) Driver Certificate or a School Bus Driver Certificate

Registry of Motor Vehicles ● Vehicle Safety & Compliance Services
Mass.Gov/RMV/7D
Schoolbus7Dnotify@dot.state.ma.us OR RMVschoolbus@dot.state.ma.us

IMPORTANT: This application must be completed, signed, and dated. Incomplete applications will be returned.

A. Medical Information and Applicant Signature

I hereby authorize the Licensed Physician completing this form to discuss and release any or all medical records pertaining to content with/or to representatives of the Registry of Motor Vehicles.

Applicant's Signature _____ Date _____

B. Patient Information **Must be completed by a Licensed Physician, NOT a Nurse Practitioner or Physician Assistant.**

Last Name	First Name	Middle Name	Suffix

Date of Birth (MM/DD/YYYY)	Driver's License #
/ /	

1. Is the applicant currently diagnosed with having diabetes? ☐ Yes ☐ No
   - ☐ Is the applicant insulin dependent? ☐ Yes ☐ No
   - ☐ Has applicant ever had a hypoglycemic episode or spell? ☐ Yes ☐ No

   If "YES" to either above, the applicant must submit a *"Diabetes Medical Evaluation Form"* completed by a Board Certified or Board eligible medical doctor in Endocrinology.
2. Does the applicant have an **Implanted Cardiac Defibrillator**? ☐ Yes ☐ No
   If "YES" the applicant must submit a *"Cardiovascular Medical Evaluation Form"* completed by a medical doctor.
3. **Distant Visual Acuity (Snellen):** Left eye: (OS)20/ _____ Right eye: (OD) 20/ _____
   - ☐ Does the applicant use corrective lenses for driving? ☐ Yes ☐ No
     (If applicant uses corrective lenses for driving, please specify visual acuity above as corrected with Rx)
   - ☐ Is the applicant's combined horizontal field of vision at least 120 degrees? ☐ Yes ☐ No
   - ☐ Is the applicant able to distinguish the colors red, green, and amber? ☐ Yes ☐ No
4. **Hearing:** Can the applicant perceive a forced **whispered voice** in the better ear at not less than five feet with or without the use of a hearing aid or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than **40 decibels** at 500Hz, 1000 Hz, and 2000Hz with or without a hearing aid when the audiometric device is calibrated to the American National Standard? ☐ Yes ☐ No
5. Does the applicant have a **Respiratory Disease/Disorder?** ☐ Yes ☐ No
   If "YES" does the applicant have an O2 saturation rate of greater than 88%, at rest or with minimal exertion, with or without supplemental oxygen? ☐ Yes ☐ No
6. Is the applicant currently diagnosed with **Epilepsy**? ☐ Yes ☐ No
7. Does the applicant have any **loss or impairment** of foot, leg, finger, hand, or arm likely to interfere with safe driving? ☐ Yes ☐ No
8. Does the applicant have any other physical condition likely to interfere with safe driving? ☐ Yes ☐ No
9. Does the applicant have any **mental, nervous, organic, or functional disease** likely to interfere with safe driving? ☐ Yes ☐ No
10. Does the applicant have any **contagious or communicable diseases**? ☐ Yes ☐ No
11. Is the applicant addicted to the use of **narcotics,** or habit-forming **tranquilizers** or **stimulants,** or the excessive use of **alcoholic beverages** or **liquors**? ☐ Yes ☐ No
12. Please check ONE BOX below:
    - ☐ **The patient named above IS medically qualified to operate a school pupil transport vehicle or a school bus and fulfill all of the duties and responsibilities associated with such operation.**
    - ☐ **The patient named above IS NOT medically qualified to operate a school pupil transport vehicle or a school bus.**

Additional Comments:

C. Physician Information and Attestation

Massachusetts NPI #		
Last Name	First Name	Middle Name

Phone #	Address
	Street City/Town

Email

I hereby certify that the information provided herein is true, accurate and complete:

Physician's Signature _____ Date: _____