



School Bus and School Pupil Transport (7D) Operator Cardiovascular Medical Evaluation Form

Instructions: The form must be completed in its entirety and signed by a licensed physician. The form must then be submitted in conjunction with a completed 7-D School Pupil Transport Certificate Application.

A. Applicant Information

Last Name		First Name		Middle Name		Suffix	
Current Massachusetts Learner's Permit or Driver's License # (if applicable)				Date of Birth (MM/DD/YYYY)			
Residential Address (Where you actually reside)							
Street		Apt. #	City		State		Zip Code
Mailing Address ☐ (same as above)							
Street		Apt. #	City		State		Zip Code

B. Physician Information and Attestation

The above applicant is applying for a driver's license to drive school pupils in Massachusetts. The applicant has an implanted cardiac defibrillator (AICD). Under the Code of MA Regulations (540 CMR 2.15), people who have an implanted cardiac defibrillator are eligible to drive school pupils if they meet certain standards. This applicant is asking you to determine whether s/he meets the following standards.

1. The AICD was implanted for a "sudden death event" and has not fired in a six-month period. ☐ Yes ☐ No

Date AICD was implanted: _____

2. The AICD was implanted for prophylactic reasons and has not fired in a six-month period. ☐ Yes ☐ No

3. The applicant is classified as either AHA functional Class I, Class II, or does not have heart disease. ☐ Yes ☐ No

4. To a reasonable degree of medical certainty, the applicant is medically qualified to operate a school bus or school pupil transport vehicle safely and fulfill any and all of the duties and responsibilities associated with such operation. ☐ Yes ☐ No

Last Name		First Name		Suffix		Board of Registration in Medicine Number	
Address							
Street		Apt. #	City		State		Zip Code
NPI #		Email					

Applicant's Signature: _____ Date: _____

I attest that, to a reasonable degree of medical certainty, the applicant is safe to operate a vehicle transporting school pupils as outlined in regulation 540 CMR 2.15.

Physician's Signature: _____ Date: _____