

STATE OF ALASKA
DIVISION OF MOTOR VEHICLES
APPLICATION FOR SCHOOL BUS LICENSE

APPLICANT MUST COMPLETE THIS SIDE PRIOR TO EXAMINATION BY A PHYSICIAN.

THIS EXAMINATION IS FOR: Original Renewal

Applicant's Name _____ Date of Birth _____

Driver License Number _____ DOE Certificate # _____

SCHOOL DISTRICT OR CONTRACTOR FOR WHOM DRIVING _____

Please answer the following questions and explain any with a "yes" answer in the space provided below:

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------|
| 1. Has an insurance company ever rejected you? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 2. Have you been committed to a mental institution or alcohol program within the last 5 years? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 3. Have you been rejected for military service? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 4. What type of military discharge? | <input type="checkbox"/> Regular | <input type="checkbox"/> Medical <input type="checkbox"/> Other |
| 5. Have you any physical defect whatsoever, which might under strain, or in the performance of your duties requiring physical alertness and muscular activities, result in disablement or otherwise incapacitate you? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 6. Are you now under or have you been under a physician's care during the past 5 years? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 7. Are you taking any medication? If yes, list them and explain below: | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 8. Have you ever received disability compensation? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 9. Do you have a problem with alcohol or drug misuse? | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 10. Have you ever or do you now have any of the following symptoms? | | |
| Chest pains | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Chronic cough | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Convulsions (fits) | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Dizziness | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Fainting spells | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Hearing loss | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Seeing double | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Spitting of blood | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| 11. Do you have or have you had any of the following in the last 5 years? | | |
| Arthritis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Asthma | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Blood disease | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Cardiac ailment | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Diabetes | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Epilepsy | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Head injuries | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Hernia (rupture) | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| High blood pressure | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Kidney trouble | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Liver disease | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Malaria | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Nervous breakdown | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Pleurisy | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Stomach trouble | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Tuberculosis | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| Varicose veins | <input type="checkbox"/> yes | <input type="checkbox"/> no |

For questions 1 - 11, explain any items in which you answered "yes":

I CERTIFY THAT THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Applicant's Signature and Date

Complete this form in triplicate

- 1) ORIGINAL COPY must accompany request for license endorsement.
- 2) ONE COPY must be sent to District School Superintendent.
- 3) ONE COPY must be given to employer.

Applicant's Name _____

Mailing Address _____
City State Zip Code

PHYSICAL EXAMINATION FOR ALASKA SCHOOL BUS DRIVER
(must be completed by a physician, physicians assistant or advanced nurse practitioner)

Height _____ Weight _____ Blood Pressure _____

VISION

Does applicant have at least 20-40 vision in one eye and 20-200 in the other eye? yes no

with corrective lenses

without corrective lenses

Does applicant have good peripheral vision? yes no

Is applicant blind in either eye? yes no

HEARING

Does applicant have normal hearing without a hearing aid? yes no

CHEST

Lungs:

Rhythm _____ Rate _____ Murmurs _____

BACK , EXTREMITIES AND JOINTS

List any abnormality: _____

To the best of your knowledge did applicant have a history of fainting spells, dizziness, convulsions, epilepsy or cardiac ailments in the 12 months immediately preceding this examination? yes no

At the time of this examination was applicant free of communicable disease? yes no

Additional remarks on any of the above conditions:

PHYSICIAN'S CERTIFICATION

I certify that I performed the physical examination of the above named individual. I further certify that based on this examination, the applicant is:

QUALIFIED **UNQUALIFIED TO OPERATE A SCHOOL BUS**

Printed Name of Physician, Physicians Assistant or Advanced Nurse Practitioner Occupational License Number

City Where Physical Performed Telephone Number

Mailing Address

Signature of Physician, Physicians Assistant or Advanced Nurse Practitioner Date of Exam