

MEDICAL EXAMINATION CERTIFICATE

for Bus Transit System Driver

I certify that I have examined _____ in accordance with the requirements in Rule 14-90.0041, Florida Administrative Code, and referenced FDOT Form 725-030-11, and with knowledge of driving duties, I find that this person:

Note certification status here and on the medical examination form.

If applicable, only when:

<input type="checkbox"/> MEETS STANDARDS (RE-EXAMINE IN 2 YEARS)	<input type="checkbox"/> Corrective Lenses	
<input type="checkbox"/> DOES NOT MEET STANDARDS	<input type="checkbox"/> Wearing hearing aid	
<input type="checkbox"/> MEETS STANDARDS, BUT PERIODIC EVALUATION REQUIRED	<input type="checkbox"/> Temporarily disqualified due to:	
DRIVER IS QUALIFIED ONLY FOR:		
<input type="checkbox"/> 3-MONTHS <input type="checkbox"/> 6-MONTHS <input type="checkbox"/> 1 YEAR <input type="checkbox"/> OTHER		
Return to medical examiner's office for follow-up on _____		
The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachments embodies my findings completely and correctly, and is on file in my office.		
Medical Examiner's Signature:	Telephone:	Date:
Medical Examiner's Name: (Print)	Medical Examiner's License or certificate number	

	Issuing State:	
	<input type="checkbox"/> MD <input type="checkbox"/> DO	<input type="checkbox"/> Physician Assistant <input type="checkbox"/> Advanced Registered Nurse Practitioner
Office Address: (Print)		
CITY	COUNTY	STATE ZIP
Name of Driver: (Print)	Driver License No.	Issuing State:
Signature of Driver:		Date: