

Insulin Dependent Waiver Packet

Background Information

An individual is not eligible to provide student transportation with an established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control. However, drivers who are insulin dependent may apply for an Insulin Dependent Waiver. For complete information, see the **School Vehicle Driver Physical Qualification Rule [OAC 3301-83-07\(F\)](#)**.

Instructions/Checklist

- ☐ **Step 1:** If noted on the T8 physical form that an Insulin Dependent Waiver is needed, contact an endocrinologist and ophthalmologist and request an appointment or verification of medical history.
- ☐ **Step 2:** Provide the endocrinologist with your **complete medical history** (including, but not limited to, the date insulin use began, all hospitalization reports, consultation notes for diagnostic examinations, special studies pertaining to the diabetes, all follow-up reports, and reports of any hypoglycemic insulin reactions within the last three years).
- ☐ **Step 3:** The endocrinologist **completes a medical evaluation** concerning your medical history and current status, including, at a minimum, the following:
 - Fasting blood studies and urinalysis performed during the last six months
 - A detailed report of insulin dosages and types, diet utilized for control and any significant factors such as smoking, alcohol use, and other medications or drugs taken
 - Assessment of proliferative diabetic retinopathy
- ☐ **Step 4:** Section II - Examining Endocrinologist Signed and Dated (page 7)
- ☐ **Step 5:** Section III - Examining Ophthalmologist Signed and Dated (page 8)
- ☐ **Step 6:** Section I – Applicant Vital Statistics/Driver’s Record Signed and Dated (page 3).
- ☐ **Step 7:** Use the secure link provided: <https://filedrop.cloudfs.ohio.gov/> to upload the Insulin Waiver Packet, including the endocrinologist statement and ophthalmologist statement. The directions are as follows:
 - Click on the link
 - Enter your name and employer /district name
 - System does a verification by sending a link to the email provided
 - You will get the verification and a link to send the documents
 - Enters recipient name and email: Ohio Department of Education & Workforce, waiverapp@education.ohio.gov

To expedite processing, please make sure that all requested information is included with the Insulin Dependent Waiver Packet.

SECTION I - DRIVER VITAL STATISTICS AND DRIVING HISTORY

The information in Section I is to be completed by the Applicant.

Have you ever been issued an insulin dependent waiver from the Department?

Yes ☐ No ☐

Please type or print clearly

Name: (Last, First, Middle initial)	
Address: (Street, City, State and Zip code)	
Phone: (Home/cell)	(Work)
Date of Birth: (month/day/year)	(Age)
Gender: Male	Female
List All State Driver License Numbers & States where the license was issued in the 3 years prior to today's date	
Diver License Issuance Date:	Expiration Date:
Driver License Classification Code:	
Employer's Name and Address:	
County of Employment:	
Employer's Telephone Number:	
Number of Years Driving a Motor Vehicle (other than a school bus or CMV):	
Number of Years Driving a school bus:	
Approximate Number of Miles driving a school bus:	
Number of Years driving a CMV driving (other than a school bus):	
Approximate Number of Miles driving a CMV (other than a school bus):	

Driving Record: Answer YES or NO to the following questions based on your driver's license record for the past 36 months prior to the date you submit the Insulin Waiver Packet.

YES	NO	SUSPENSION/REVOCATION OF LICENSE
YES	NO	REPORTABLE ACCIDENT AND CITED FOR A MOVING VIOLATION
YES	NO	SERIOUS TRAFFIC VIOLATION as defined in division (II) of section 4506.01 of the Revised Code

For all YES answers explain or describe the violations:

Signature

In signing and submitting this document, I hereby certify that I have read, understand, and will adhere to all rules and requirements pertinent to the insulin dependent waiver as administered by the Ohio Department of Education and Workforce. I understand that my waiver may be revoked for a failure to adhere to any or all of the rules and requirements, and under no circumstance will I be afforded an appeal to such revocation.

Applicant Signature	
Date	

SECTION II – ENDOCRINOLOGIST STATEMENT [OAC 3301-83-07\(F\)](#)

Applicant (Patient) Name and Date of Birth:

This section is to be completed by a licensed endocrinologist. The endocrinologist must indicate waiver approval or waiver disapproval, and sign and date at the bottom of Section II.

YES	NO	Endocrinologist Exam Completed
YES	NO	The Endocrinologist is familiar with the applicant's medical history for the past three years either through actual treatment or through consultation with a physician who has treated the applicant during that time.
YES	NO	The applicant has been using insulin to control their diabetes on the date of the application.
YES	NO	The applicant does not have severe hypoglycemia or episodes of altered consciousness requiring the assistance of another person to regain control.
YES	NO	The applicant does not have hypoglycemia unawareness or the inability to recognize the early symptoms of hypoglycemia such as sweating, anxiety, forceful heartbeat, and lightheadedness.
YES	NO	Within the past three years, the applicant has not had a hypoglycemic reaction, at any time, that resulted in any change in mental status that would have been, in the endocrinologist's opinion, detrimental to safe driving.
YES	NO	The applicant's diabetic condition will not adversely affect their ability to operate a school transportation vehicle.
YES	NO	The applicant has been educated in diabetes and its management, thoroughly informed of, and understands the procedures which must be followed to monitor and manage their diabetes and what procedures should be followed if complications arise.
YES	NO	The applicant has the ability and has demonstrated willingness to properly monitor and manage their diabetes.

ENDOCRINOLOGIST'S STATEMENT PROVIDING REASONS FOR THE APPROVAL OR DISAPPROVAL OF AN INSULIN DEPENDENT WAIVER

- ☐ I recommend waiver approval
- ☐ I do not recommend waiver approval

Endocrinologist signature

X

Endocrinologist License Number: _____

Date: _____

SECTION III – OPHTHALMOLOGIST STATEMENT [OAC 3301-83-07\(F\)](#)

Applicant (Patient) Name and Date of Birth:

This section is to be completed by a licensed ophthalmologist. The ophthalmologist must indicate waiver approval or waiver disapproval, and sign and date at the bottom of Section III.

YES	NO	Ophthalmologist Exam Completed
YES	NO	Applicant does not have unstable proliferative diabetic retinopathy.
YES	NO	Applicant does not have unstable advancing disease of blood vessels in the retina.
YES	NO	Applicant has stable visual acuity (at least 20/40 Snellen in each eye separately, with or without corrective lenses).

OPHTHALMOLOGIST STATEMENT PROVIDING REASONS FOR THE APPROVAL OR DISAPPROVAL OF AN INSULIN DEPENDENT WAIVER

- ☐ I recommend waiver approval
☐ I do not recommend waiver approval

Ophthalmologist signature



Ophthalmologist License Number: _____

Date: _____