



DR. ROXANNE DIETZLER, PC
Occupational Medicine & Family Practice

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Telephone: (757) 599-3623
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PATIENT NAME: _____ DATE: _____

PATIENT DOB: _____

Dear Cardiologist,

Your patient has a bus driver physical coming up. If the individual has had a bypass or stent, they will need to have a cardiology clearance to maintain their certification as well as periodic stress testing.

They must have a negative ETT, at least two year exercising to a workload capacity of at least six METS, maintain a heart rate greater than or equal to 85% of predicted maximum, rise in systolic BP greater than or equal to 20 mm HG without angina, and no significant ST segment depression or elevation. Stress radionuclide or ECHO imaging should be performed for symptomatic individuals, individuals with abnormal resting EKG or those driver who fail to obtain the minimum standards required from the standard ETT.

For all other cardiac conditions, a stress test or echo may or may not be necessary.

The patient must be tolerating all cardiovascular medication without orthostatic symptoms, including symptomatic lightheadedness.

Please complete the form and return to the individual so I can perform their bus driver physical.

Thank you for your

Sincerely,

Roxanne Dietzler, DO, FAAFP



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PATIENT NAME: _____

DATE: _____

PATIENT DATE OF BIRTH: _____

Dear Cardiologist:

Your patient is coming in for a bus driver physical. Since I do not know or treat this individual, I require information to determine if the individual is safe to operate the vehicle based on the condition you treat.

CARDIAC CONDITION FORM

1. What cardiac condition (s) do you treat? _____

2. What medications does the patient take for the cardiac condition?

3. Is the patient compliant with appointments? _____

4. Is the patient's condition stable? _____

5. Is the treatment efficacious? _____

6. Is the patient free from medication side effects? _____

7. In your medical opinion, is the individual safe to operate a school bus without the risk for sudden incapacitation or death thus endangering public safety? _____

8. Comments: _____

Physician Signature: _____ Date: _____

Stamp or complete below

Physician Name, Address and Phone Number: