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PATIENT NAME: _____ DATE:_____

PATIENT DATE OF BIRTH: _____

MENTAL HEALTH QUESTIONNAIRE FOR BUS DRIVERS

What is/are the diagnosis for which you treat this driver?

_____

_____

What medication(s) is the driver taking (Name, dose, schedule)?

_____

_____

_____

Is the driver compliant with medical appointments and the treatment program?_____

Is the treatment efficacious?_____

Is the driver tolerating treatment without side effects such as sedation, impaired coordination,etc that would cause safety sensitive risks?_____

In your medical opinion does the driver have a medical condition and/or treatment plan that would result in a higher than acceptable likelihood for gradual or sudden incapacitation or sudden death that would endanger public safety?_____

Do you have any concerns about your patient being certified to drive a bus? _____

Physician Signature:_____ Date:_____

Stamp or complete below
Physician Name, Address and Phone Number: