Lafayette Parish School System
Substitute Bus Driver Application

Please complete in its entirety all pages in this application. This application must be returned to the Office of Human Resources with all required documents. Once **ALL** documents are completed, the applicant may schedule an appointment for background fingerprinting at https://lpsshr.appointlet.com. Once the applicant's background is reviewed and approved, the application will be processed. If you have any questions concerning this application, please contact our office at 337-521-7050.

Substitute Bus Driver Application Checklist

- ☐ Substitute Bus Driver Application
- ☐ Procedures and Information Approval
- ☐ Sexual Harassment Policy
- ☐ Signed copy of Job Description
- ☐ LA OWCA Second Injury Board Knowledge Questionnaire
- ☐ CDL Physical Examination Form
- ☐ Medical Examiner's Certificate
- ☐ Bus Driver Training Verification Form
- ☐ I-9 Form
- ☐ W-4 Form
- ☐ L-4 Form

Required Documents *(Attach copies of the following documents)*:

- ☐ Copy of Driver's License with Passenger and School Bus Endorsement
- ☐ Copy of Social Security Card
- ☐ Copy of Birth Certificate
- ☐ Copy of Proof of High School Diploma/GED or signed Adult Ed. Evaluation Plan
- ☐ Copy of Defensive Driving Certificate
- ☐ Copy of CPR/First Aid Certification

Human Resources Office Use Only:

- ✧ Notify Transportation Office to request Driving Record from LA DPS
  - ☐ Yes, emailed:_____
- ✧ All documents are completed. The applicant can be processed for a background check:
  - ☐ Background Check (Completed in the LPSS Human Resources Office)

LAFAYETTE
PARISH SCHOOL SYSTEM

Strength. Tradition. Excellence.

Date Received Stamp (HR Use Only)

Substitute Bus Driver Application

PERSONAL INFORMATION

Last Name	*First Name*		*Middle Name*
Street Address	*City*	*State*	*Zip Code*
Date of Birth	*Social Security Number*	*Home Telephone*	*Cellular Telephone*
Driver's License/I.D. Number	*State of Issuance*		*Email Address (Required)*

EMERGENCY CONTACTS

Last Name, First Name	*Relationship*	*Telephone Number*
Last Name, First Name	*Relationship*	*Telephone Number*

EDUCATION

High School/G.E.D. Program	*Highest Grade Level Attained*	*Year Graduated*
College Attended	*Number of Years Completed*	*Degree Awarded (Please Specify Major)*

EMPLOYMENT HISTORY

Name of Employer	*Time Period Worked*	*Position Held*	*Name of Immediate Supervisor*	*Telephone Number*
Name of Employer	*Time Period Worked*	*Position Held*	*Name of Immediate Supervisor*	*Telephone Number*
Name of Employer	*Time Period Worked*	*Position Held*	*Name of Immediate Supervisor*	*Telephone Number*

MILITARY EXPERIENCE

PLEASE LIST YOUR MILITARY EXPERIENCE

_____

_____

_____

THE LAFAYETTE PARISH SCHOOL SYSTEM IS AN EQUAL OPPORTUNITY EMPLOYER

Revised: October 5, 2010

GENERAL INFORMATION

Question	Yes	No	If Yes, Please Explain.
Have you ever been employed with the Lafayette Parish School System?			
Are you currently receiving benefits from Louisiana/School Employee's Retirement System?			
Are you related to any person currently serving as a board member of the Lafayette Parish School System?			
List any members of your immediate family who are employed by the Lafayette Parish School System?			
Have you ever been discharged or requested to resign from a position?			
Have you ever been convicted of a violation of the law other than a minor traffic violation?			
Do you currently have a criminal charge pending against you?			
Have you ever been convicted of a criminal charge?			
Have you ever been convicted of any offense involving the sexual molestation, physical or sexual abuse, or rape of a child?			
Are you currently enrolled in a Teacher Candidacy program? If so, please list the semester planning to student teach?			

QUESTIONNAIRE

Briefly, please explain why you would like to become a substitute.

_____

_____

_____

Briefly, please explain your strengths that you believe will benefit you as a substitute.

_____

_____

_____

Briefly, please explain your weakness that you believe will pose a challenge for you as a substitute.

_____

_____

_____

DISCLOSURE: As part of the employment process, **LAFAYETTE PARISH SCHOOL BOARD** (LPSB), will obtain a consumer report which I understand may include information regarding my character, general reputation or personal characteristics as authorized by L.R.S. 15:587.1 for Educational Requests.

AUTHORIZATION: During the application process and at any time during the tenure of my employment with LPSB, I hereby authorize the LPSB to procure a consumer report which I understand may include information regarding my character, general reputation or personal characteristics. This report may be compiled with information from credit bureaus, courts record repositories, departments of motor vehicles, past or present employers and educational institutions, governmental occupational licensing or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification; to the extent such investigation includes information bearing on my character, general reputation or personal characteristics.

_____ _____

Applicant Name (Please Print) *Date*

_____-_____-_____ _____ _____

*Social Security Number ** *Date of Birth ** *Applicant Signature*

* For Identification Purposes Only

THE LAFAYETTE PARISH SCHOOL SYSTEM IS AN EQUAL OPPORTUNITY EMPLOYER

Revised: October 5, 2010

Procedures and Information Approval

You **MUST** submit a completed application to the Human Resource Office and have it processed prior to beginning employment with the Lafayette Parish School System. Starting employment prior to having a completed application will void any days worked. ***INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTS ARE ATTACHED. SUBSTITUTE APPLICATIONS ARE HELD FOR A MAXIMUM OF SIXTY (30) DAYS. FAILURE TO COMPLETE A CRIMINAL BACKGROUND CHECK OR SUBSTITUTE INSERVICE WILL RESULT IN THE APPLICATION BEING DESTROYED.***

Applications and all attached documents cannot be returned or duplicated. Please copy any paperwork needed prior to submitting them to the Human Resource Office.

Personal Information Changes:
To modify any identity information, such as name, address, and telephone number, the substitute must complete a "Change of Address" Form. Changes will be posted within two (2) to four (4) business days after receiving this form. This form and others can be found at http://www.lpssonline.com/forms.

Records of Arrest:
A criminal record does not automatically disqualify a substitute from employment within our school district. All backgrounds containing a record **MUST** be approved by the Director of Human Resources (or his/her designee) prior to the completion of processing your application.

Retirement:
It is the responsibility of the applicant to notify the Lafayette Parish School System that he/she are a retired employee with the Louisiana Teachers' Retirement System.

Standards:
All substitute applications will stay active as long as you are working for the Lafayette Parish School System. Failure to work for the Lafayette Parish School System for three (3) consecutive months will render the application inactive, in which case the supplemental employee will have to restart the application process.

I, hereby agree to abide by the above procedures and information during my employment with the Lafayette Parish School System. I understand that any violation of these and any other policies may result in disciplinary action or termination of my employment. I also understand that any changes in district policy or law could cause changes to the above information.

Signature: _____ Date: _____

LAFAYETTE PARISH SCHOOL SYSTEM

File: GAEAA
File: GAEAAR

SEXUAL HARASSMENT POLICY

STATEMENT

The Lafayette Parish School Board recognizes that sexual harassment is an unlawful act that affects everyone, including women and men, all workers at all levels, and all types of work. The Board is committed to maintaining a fair and respectful work environment for all employees.

POLICY

It shall be the policy of the Board, in connection with all Board employment, to:

1. prohibit and discourage any employee from sexually harassing another employee or job applicant;
2. provide a harassment-free work environment;
3. remedy in a speedy manner any consequences of sexual harassment;
4. provide information about how to pursue claims of sexual harassment.

REGULATIONS

1. DEFINITION OF SEXUAL HARASSMENT

A. Sexual harassment includes unwelcome sexual advances, requests for sexual favors or other verbal or physical conduct of a sexual nature which made an employment condition so that submission to such conduct is a term or condition of employment; an employment consequence, so that submission to or rejection of such conduct is used as a basis for employment decisions affecting an individual employee; or an offensive job interference, so that such conduct has the purpose or effect of unreasonably interfering with an employee's work performance or creating an intimidating, hostile or offensive work environment.

B. Sexual harassment may include, but is not limited to, verbal harassment including epithets, derogatory comments or slurs, physical harassment, physical interference with movement or work, or visual harassment such as derogatory cartoons, drawings or posters.

C. Sexual harassment is prohibited against members of the same sex as well as against members of the opposite sex.

2. PROHIBITED SUPERVISORY BEHAVIOR

A. No supervisor may condition any employment, employee benefit or continued employment in this school system on an applicant's or employee's acquiescence to any of the sexual behavior defined above.

B. No supervisor may retaliate against any applicant or employee because that applicant or employee has opposed a practice prohibited by Title VII of the Civil Rights Act of 1965 and the new Civil Rights Act of 1991, or has filed a complaint, testified, assisted or participated in any manner in an investigation, proceeding or hearing conducted by an authorized investigative agency.

C. No supervisor or manager shall destroy evidence relevant to an investigation of sexual discrimination.

3. BEHAVIOR PROHIBITED BY ALL EMPLOYEES

A. No supervisor or any other employee of this school system shall create a hostile or offensive work environment for any other employee by engaging in any sexual harassment or by tolerating it on the part of any supervisor.

B. No supervisor or any other employee in the school system shall assist any individual in doing any act which constitutes sexual discrimination against any employee of the school system.

4. OBLIGATIONS OF SUPERVISORS

A. Preventive Action

1) A copy of this policy shall be distributed to all employees.
2) A copy of this policy shall be given to any new employee within one week of their employment.

B. Investigative/Corrective Action

1) All supervisors shall immediately report any evidence of sexual harassment or complaints regarding sexual harassment made to them to the Director of Schools or Director of Human Resources.
2) All supervisors shall, within five working days, investigate any incident of alleged sexual harassment reported to them.
3) All supervisors shall immediately report in writing the results of any investigation of sexual harassment, including corrective or disciplinary action taken to the appropriate director and to the complaining applicant/employee.
4) All supervisors shall immediately report to the appropriate director, any instances of sexual harassment which they have directly observed whether or not reported by the employee who is the object of the harassment.
5) Under no circumstances shall an employee of the Board who believes that he or she has been the victim of sexual harassment be required to first report that harassment to a supervisor if the supervisor is the individual who has done the harassing. An employee who has a claim of sexual harassment to file against an immediate supervisor shall contact the Director of Schools or the Director of Human Resources.
6) Under no circumstances shall a supervisor retaliate in any way against an employee who has provided information as a witness to an incident of sexual harassment.
7) All supervisors are required to maintain confidentiality in investigating any claims of alleged harassment.
8) All supervisors shall follow up within one month and again in three months of any reported incident of sexual harassment to determine whether the victim has been subject to any further forbidden conduct.

5. CONSEQUENCES FOR VIOLATION OF POLICY

Any employee who violates this policy shall be subject to disciplinary action, in accordance with Board policy, up to and including discharge.

Signature of Applicant: _____ Date: _____/_____/_____

Code of Federal Regulations 29 CFR Chapter XIV 1604.11
Adopted: 04/21/93 Revised: 10/21/98
Lafayette Parish Public Schools, Louisiana

THE LAFAYETTE PARISH SCHOOL SYSTEM IS AN EQUAL OPPORTUNITY EMPLOYER

3001
Non-Exempt

JOB TITLE: **SCHOOL BUS DRIVER**

QUALIFICATIONS: High school diploma or GED

REPORTS TO: Director of Transportation; Principal

JOB GOAL: Transports students, teachers, and authorized personnel in a bus for the Lafayette Parish School System

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MAJOR DUTIES AND RESPONSIBILITIES

- Transports only students, teachers, and authorized personnel
- Discharges students only at authorized stops
- Maintains bus in a safe and clean condition
- Reports all accidents and completes required reports immediately
- Becomes familiar with and adheres to applicable policies, statutes, and procedures set forth in State Bulletin 1475, Operational and Vehicle Maintenance Procedures; State Bulletin 1191, School Transportation Handbook; and Lafayette Parish School System Bus Driver and Bus Attendant Handbook
- Maintains student discipline on the bus and reports misbehavior to proper school authorities
- Notifies the proper authority in case of mechanical failure or delays
- Completes all required forms and returns them promptly
- Attends periodic safety meetings and attends a minimum of eight hours in-service training biannually
- Adheres to assigned route and schedule
- Cooperates with other drivers in case of emergency
- Drives regular assigned routes and extra routes during the school day as assigned by the Director of Transportation
- Special Education bus drivers must maintain a daily bus log (attendance record) showing whether students rode the bus each day.
- Contract Bus Drivers must maintain a current student roster of students assigned to their bus routes.
- Performs other duties as may be assigned by the Director of Transportation or the Coordinators
- Works a minimum of 23 hours per week which includes driving time, dead mileage, pre-trip inspections, up-keep of bus, stand-by time, extra routes, and field trips

REQUIREMENTS OF WORK

- High school diploma or GED
- Must have valid commercial driver's license (CDL) with passenger endorsement
- Must be 21 years of age or older
- Must have three years or 36,000 miles driving experience without any chargeable major accidents or traffic violations

School Bus Driver

- Must complete forty hours of pre-service training as outlined in Bulletin 1191
- Must pass the CDL physical examination required for bus drivers
- Must complete a physical examination and a psycho-physical examination prior to each school year
- Must be physically able to assist in lifting and transferring students to seat or to assist in evacuation

TERMS OF EMPLOYMENT

Pay Grade: Bus Drivers' Salary Schedule
Working Days: 180

The above statements are intended to describe the general purpose and responsibilities assigned to this job and are not intended to represent an exhaustive list of all responsibilities, duties, and skills required.

APPROVED BY:_____DATE:_____

REVIEWED AND AGREED BY:_____DATE:_____

WORKING CONDITIONS
The following physical demands/environmental factors are representative. While the general working conditions are not exhaustive, the information is intended to inform all parties. These are not designed to deprive anyone of his/her rights under any state or federal law.

Physical Demands/ Environmental Factors:

Lifting: heavy (50 pounds and over)	Standing, intermittent
Carrying: heavy (50 pounds and over)	Protracted or irregular hours of work
Exposure to excessive heat, cold, and humidity	Operation of motor vehicle
Pushing	Specific visual requirements for driving
Reaching above shoulder	Walking, intermittent
Use of fingers	Depth perception
Exposure to dust	Ability to distinguish basic colors
Occasional exposure to excessive noise	Occasional exposure to fumes or smoke

Unusual fatigue factors (long hours of driving on field trips)
Specific hearing requirements (driving, oral and phone conversations)

LOUISIANA WORKFORCE COMMISSION

1001 North 23rd Street
Post Office Box 44187
Baton Rouge, LA 70804-4187

(O) 225-342-7866
800-201-2493
(F) 225-219-5968

Bobby Jindal, Governor
Curt Eysink, Executive Director

Office of Workers' Compensation Administration
Second Injury Board

LA OWCA Second Injury Board Knowledge Questionnaire

The following questionnaire should only be completed by individuals that have been hired for employment. Your employer may ask that you complete this questionnaire following your initial hire and periodically thereafter.

The questionnaire may be used in the establishment of prior knowledge for the purpose of obtaining Second Injury Fund relief from the Second Injury Board. The Second Injury Board may reimburse your employer for workers' compensation claims that meet certain criteria should you become injured on the job. This reimbursement in no way affects the benefits owed to you by your employer or their insurance company under the Louisiana Workers' Compensation Act, La. R.S. 23:1021-1361.

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

Employer: _____

Employee Name:_____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only):_____

Home Address: _____

Telephone Number:(____) _____

Employee Signature:_____ Date: _____

Employer Witness: _____ Date: _____

Please place a check in the appropriate box next to each medical condition listed below. Each illness or condition requires a Yes (Y) or No (N) answer. For all conditions that you check yes, write a brief explanation on the Explanation Page.

Disease and Other Medical Conditions [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystropy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertention	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N

☐ ☐ Spinal Disc Surgery Year (approximate if unsure)_____

☐ ☐ Spinal Fusion Surgery Year (approximate if unsure)_____

☐ ☐ Amputated Foot Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Leg Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Arm Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Hand Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Knee Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Hip Replacement Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Other Joint Replacement Joint _____ Year _____

☐ ☐ Other Surgical Procedure Procedure _____ Year _____

Employee Signature:_____ Date: _____

Employer Witness: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: ____ Year Diagnosed (approx): ______________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

CONDITION: ____ Year Diagnosed (approx): ______________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

CONDITION: ____ Year Diagnosed (approx): ______________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

CONDITION: ____ Year Diagnosed (approx): ______________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ____

Employee Signature: ______________________________________ Date: __________________________

Employer Witness: ____ Date: __________________________

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐
   If "Yes," please list the restrictions: _____
   Were the restrictions: Permanent ____ Temporary ____
   Are you currently restricted? Yes ☐ No ☐
   What is the medical condition for which you are restricted? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

   Please list the medical condition being treated: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

3. If you are presently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

   Medication: _____Prescribing Doctor: _____

   Medication: _____Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐
   If you answered "YES," please provide the date for each injury and the nature of the injury:

   _____

   How long were you on compensation? _____

   Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐
   If you answered YES, please provide:

   Recommended surgery: _____

   Approximate date of recommendation: _____

   Doctor's Name: _____Specialty: _____

   Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature:_____ Date: _____

Employee Printed: _____

I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation Page as needed. I have confirmed the number of and labeled the pages of this questionnaire.

Employer Witness: _____ Date: _____

Employer Witness Printed: _____

Title: _____

Louisiana Department of Public Safety & Corrections
Office of Motor Vehicles
CDL PHYSICAL EXAMINATION FORM

(Meets Department of Transportation Requirements)

Date of Examination: _____ New Certification ☐ Re-certification ☐ Follow up ☐

1. DRIVER'S INFORMATION: Driver completes this section.

Driver's Name: _____

Address: _____

Soc. Sec. No. _____ Date of Birth _____ Age _____ Race/Sex _____

Driver's License No. _____ Class _____ State _____ Telephone: _____

2. HEALTH HISTORY: Driver completes this section, but medical examiner is encouraged to discuss with driver.

Yes	No		Yes	No	
☐	☐	Any illness or injury in last 5 years?	☐	☐	Diabetes or elevated blood sugar controlled by: ☐ diet ☐ pills ☐ insulin
☐	☐	Head/Brain injuries, disorders or illnesses			
☐	☐	Seizures, epilepsy If yes, specify medication _____	☐	☐	Nervous or psychiatric disorders, severe depression If yes, specify medication _____
☐	☐	Eye disorders or impaired vision (except corrective lenses)	☐	☐	Loss of or altered consciousness
☐	☐	Ear disorders, loss of hearing or balance	☐	☐	Fainting, dizziness
☐	☐	Heart disease or heart attack; other cardiovascular condition If yes, specify medication _____	☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)	☐	☐	Stroke or paralysis
☐	☐	High blood pressure If yes, specify medication _____	☐	☐	Missing or impaired hand, arm, foot, leg, finger or toe
☐	☐	Muscular disease	☐	☐	Spinal injury or disease
☐	☐	Shortness of breath	☐	☐	Chronic low back pain
☐	☐	Lung disease, emphysema, asthma, chronic bronchitis	☐	☐	Regular, frequent alcohol use
☐	☐	Kidney disease, dialysis	☐	☐	Narcotic or habit forming drug use
☐	☐	Liver disease			
☐	☐	Digestive problems			

For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitations. List all medications (including over the counter medications) used regularly or recently.

_____

_____

_____

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

_____ _____

Driver's Signature Date

Medical Examiners's Comments on Health History (The medical examiner must review and discuss with the driver any YES answers and potential hazards of medications including over-the-counter medications while driving. Should additional medical documentation from a treating physician be warranted prior to determining if the driver meets the minimum requirements, said documentation should become a part of his/her medical file which is maintained in your office.) Discussion with driver should be documented below.

_____

_____

_____

Is the condition(s) likely to hamper the driver's ability to control and/or safely operate a commercial motor vehicle? Yes ☐ No ☐

Does treatment/medication utilized cause any side affects that are likely to hamper the ability to control and/or safely operate a commercial motor vehicle? Yes ☐ No ☐

NAME: _____

TESTING Medical examiner completes Section 3 through 7

3. VISION: Standard: At least 20/40 distance acuity (Snellen) in each eye with or without correction. At least 70 degree peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certification.

INSTRUCTIONS: *When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. Monocular drivers are not qualified.*

Numerical reading must be provided:

ACUITY (Distance)	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION	Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors? ☐Yes ☐No
Right Eye	20/_____	20/_____	Right Eye _____ degrees	
Left Eye	20/_____	20/_____	Left Eye _____ degrees	
Both Eyes	20/_____	20/_____		

Applicant meets visual acuity requirement only when wearing:_____ Corrective lenses

Monocular Vision?: Yes ☐ No ☐

Complete next line only if vision testing is done by an ophthalmologist or optometrist:

Date of Exam	Printed Name of Ophthalmologist/Optometrist	Signature
	Telephone Number	License No/State of Issue

4. HEARING: Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40 dB.

☐ Check if hearing aid used for tests. ☐ Check if hearing aid **required** to meet standard

INSTRUCTIONS: *To convert audiometric test results from ISO to ANSI, -14 dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 Db for 2,000 Hz. To average, add the readings for 3 frequencies tested and divide by 3.*

Numerical readings must be recorded.

A) Record distance from individual at which forced whispered voice can first be heard. Right Ear _____ ft. Left Ear _____ ft.

B) If audiometer is used, record hearing loss in decibels. (Acc. To ANSI Z24.5-1951)

	500 Hz	1000 Hz	2000 Hz	Average
Right Ear	_____	_____	_____	_____
Left Ear	_____	_____	_____	_____

5. BLOOD PRESSURE/PULSE RATE - Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm BP.

Blood Pressure	Systolic	Diastolic

Driver qualified if ≤140/90.

Pulse Rate: ☐ Regular ☐ Irregular
Record Pulse Rate:

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 year	1 year if ≤140/90. One-time certificate for 3 months if 141-159/91-99.
160-179/100-109	Stage 2	One-time certificate for 3 months.	1 year from date of exam if ≤ 140/90
≥180/110	Stage 3	6 months from date of exam if ≤140/90	6 months if ≤140/90

NOTE: Medical Examiner should take at least 2 readings to confirm blood pressure prior to posting reading on this form.

NAME: _____

6. LABORATORY AND OTHER TEST FINDINGS **Numerical readings must be recorded.**
Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problems.

	Sp. Gr.	Protein	Blood	Sugar
URINE SPECIMEN:	_____	_____	_____	_____

Other Tests (Describe and record) _____

_____

_____

_____

_____

7. PHYSICAL EXAMINATION Height: _____ (inches) Weight: _____(lbs)
The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately and is not likely to worsen or is readily amendable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.
Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See *Instructions to the Medical Examiner* for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO
1. General appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	☐	☐
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration. Refer to a specialist if appropriate.	☐	☐
3. Ears	Scarring of the tympanic membrane, occlusion of external canal, perforated eardrums.	☐	☐
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.	☐	☐
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	☐	☐
6. Lungs and chest, not including breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rates, impaired respiratory function, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.	☐	☐
7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.	☐	☐
8. Vascular system	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.	☐	☐
9. Genito-urinary systems	Hernias.	☐	☐
10. Extremities - Limbs impaired. Driver may be subject to SPE certificate if otherwise qualified.	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient mobility and strength in lower limb to operate pedals properly. Insufficient grasp and prehension in upper limb to maintain steering wheel grip.	☐	☐
11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness	☐	☐
12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.	☐	☐

*Comments

_____

_____

_____

_____

_____

NAME: _____

Note certification status here. See *Instructions to the Medical Examiner* for guidance.

I certify that _____
Name of Driver

_____ Meets standards in 49 CRF 391.41-49; qualifies for 2 year certificate

_____ Does not meet standards

_____ Meets standards, but periodic evaluation required.

_____ Wearing corrective lenses
_____ Wearing hearing aid
_____ Accompanied by a_____waiver/exemption
_____ Skill Performance Evaluation (SPE) Certificate
_____ Driving within an exempt intra-city zone
_____ Qualified by operation of 49 CFR 391.64
(vision or insulin dependent waiver program)

Due to _____driver qualified only for: ____ 3 months ____1 year ____ 6 months ____ Other

_____ Temporarily disqualified due to (condition or medication): _____

Return to medical examiner's office for follow up on: _____

_____ _____
Name of medical examiner (print) Signature of medical examiner

_____ _____
Address of medical examiner Telephone number of medical examiner

If meets standards, complete a Medical Examiner's Certificate (at the back of this form) as stated in 49 CFR 391.43(h).

TO BE COMPLETED BY PATIENT

I hereby authorize and request the physician who has examined and whose signature appears above to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a commercial motor vehicle.

_____ _____
Date Signature of Patient

OMV COMPLETES THIS SECTION

REVIEWED BY	DATE	FIELD OFFICE	APP. DATE

HEADQUARTER'S REVIEW

49 CFR 391.41
Physical Qualifications for Drivers

THE DRIVER'S ROLE

Responsibilities, work schedules, physical and emotional demands, and lifestyles among commercial drivers vary by the type of driving that they do. Some of the main types of drivers include the following: turn around or short relay (drivers return to their home base each evening); long relay (drivers drive 9-11 hours and then have at least a 10 hour off-duty period), straight through haul (cross country drivers); and team drivers (drivers share the driving by alternating their 5-hour driving periods and 5-hour rest periods).

The following factors may be involved in a driver's performance of duties: abrupt schedule changes and rotating work schedules, which may result in irregular sleep patterns and a driver beginning a trip in a fatigued condition; long hours; extended time away from family and friends, which may result in lack of social support; tight pickup and delivery schedules, with irregularity in work, rest, and eating patterns, adverse road , weather and traffic conditions, which may cause delays and lead to hurriedly loading or unloading cargo in order to compensate for the lost time; and environmental conditions such as excessive vibration, noise, and extremes in temperatures. Transporting passengers or hazardous materials may add to the demands on the commercial driver.

There may be duties in addition to the driving task for which a driver is responsible and needs to be fit. Some of these responsibilities are: coupling and uncoupling trailer(s) from the tractor; loading and unloading trailer(s) (sometimes a driver may lift a heavy load or unload as much as 50,000 pounds of freight after sitting for a long period of time without any stretching period); inspecting the operating condition of tractor and trailer(s) before, during, and after delivery of cargo; lifting, installing and removing heavy tire chains; and lifting heavy tarpaulins to cover open top trailers. The above tasks demand agility, the ability to bend and stoop, the ability to maintain a crouching position to inspect the underside of the vehicle, frequent entering and exiting of the cab, and the ability to climb ladders on the tractor and/or trailer(s).

In addition, a driver must have the perceptual skill to monitor a sometimes complex driving situation, the judgment skills to make quick decisions, when necessary, and the manipulative skills to control an oversize steering wheel, shift gears using a manual transmission, and maneuver a vehicle in crowded areas.

391.41 PHYSICAL QUALIFICATION FOR DRIVERS

a) A person shall not drive a commercial motor vehicle unless he is physically qualified to do so and, except as provided in 391.67, has on his person the original, or a photographic copy, of a medical examiner's certificate that he is physically qualified to drive a commercial motor vehicle.

b) A person is physically qualified to drive a motor vehicle if that person:

1) Has no loss of a foot, a leg, a hand, or an arm, or has been granted a Skill Performance Evaluation (SPE) Certificate (formerly Limb Waiver Program) pursuant to 391.49.

2) Has no impairment of; (i) A hand or finger which interferes with prehension or power grasping; or (ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or any other significant limb defect or limitation which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or has been granted a SPE Certificate pursuant to 391.49.

3) Has no established medical history or clinical diagnosis of diabetes mellitus currently requiring insulin for control;

4) Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure.

5) Has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with his ability to control and drive a commercial motor vehicle safely.

6) Has no current clinical diagnosis of high blood pressure likely to interfere with his ability to operate a commercial motor vehicle safely.

7) Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease which interferes with his ability to control and operate a commercial motor vehicle safely.

8) Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a commercial motor vehicle.

9) Has no mental, nervous, organic, or functional disease or psychiatric disorder likely to interfere with his ability to drive a commercial motor vehicle safely.

10) Has distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green and amber.

11) First perceives a forced whispered voice in the better ear not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard (formerly ASA Standards) 224.5-1951.

12) (i) Does not use a controlled substance identified in 21 CFR 1308.11 Schedule I, an amphetamine, a narcotic, or any other habit-forming drug. (ii) Exception: A driver may use such a substance or drug, if the substance or drug is prescribed by a licensed medical practitioner who: (A) Is familiar with the driver's medical history and assigned duties; and (B) has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

13) Has no current clinical diagnosis of alcoholism. *For further information, see INSTRUCTIONS TO MEDICAL EXAMINER included in this form.*

INSTRUCTIONS TO THE MEDICAL EXAMINER

General Information

The purpose of this examination is to determine a driver's physical qualification to operate a commercial motor vehicle (CMV) in interstate commerce according to the requirements in 49 CFR 391.41-49. Therefore, the medical examiner must be knowledgeable of these requirements and guidelines developed by the FMCSA to assist the medical examiner in making the qualification determination. The medical examiner should be familiar with the driver's responsibilities and work environment and is referred to the section on the form. The Driver's Role.

In addition to reviewing the Health History section with the driver and conducting the physical examination, the medical examiner should discuss common prescriptions and over-the-counter medications relative to the side effects and hazards of these medications while driving. Educate driver to read warning labels on all medications. History of certain conditions may be cause for rejection, particularly if required by regulation, or may indicate the need for additional laboratory tests or more stringent examinations perhaps by a medical specialist. These decisions are usually made by the medical examiner in light of the driver's job responsibilities, work schedule and potential for the condition to render the driver unsafe.

Medical conditions should be recorded even if they are not cause for denial, and they should be discussed with the driver to encourage appropriate remedial care. This advice is especially needed when a condition, if neglected, could develop into a serious illness that could affect driving.

If the medical examiner determines that the driver is fit to drive and is also able to perform non-driving responsibilities as may be required, the medical examiner signs the medical certificate which the driver must carry with his/her license. The certificate must be dated. Under current regulations, the certificate is valid for 2 years, unless the driver has a medical condition that does not prohibit driving but does require more frequent monitoring. In such situations, the medical certificate should be issued for a shorter length of time. The physical examination should be done carefully and at least as complete as indicated by the attached form. Contact the FMCSA at (202) 366-1790 for further information (a vision exemption, qualifying drivers under 49 CFR 391.64, etc).

Interpretation of Medical Standards

Since the issuance of the regulations for physical qualifications for commercial drivers, the Federal Motor Carrier Safety Administration (FMCSA) has published recommendations called Advisory Criteria to help medical examiners in determining whether a driver meets the physical qualifications for commercial driving. These recommendations have been condensed to provide information to medical *examiners that (1) is directly relevant to the physical* examination and (2) is not already included in *the medical* examination form. *The specific regulation is* printed in *italics and* its reference by section is highlighted.

Federal Motor Carrier Safety Regulations
-Advisory Criteria-

Loss of Limb: 391.41(b)(1)

A person is physically qualified to drive a commercial motor vehicle if that person:
Has no loss of a foot, leg, hand or an arm, or has been granted a Skill Performance Evaluation (SPE) Certificate pursuant to Section 391.49.

Limb Impairment: 391.41(b)(2)

A person is physically qualified to drive a commercial motor vehicle if that person: *Has no impairment of., (i) A hand or finger which interferes with prehension or power grasping; or (ii) An arm, foot, or leg which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; or (iii) Any other significant limb defect or limitation which interferes with the ability to perform normal tasks associated with operating a commercial motor vehicle; Perform normal tasks associated with operating a commercial motor vehicle; or (iv) Has been granted a Skill Performance Evaluation Certificate pursuant to Section 391.49.*

A person who suffers loss of a foot, leg, hand or arm or whose limb impairment in any way interferes with the safe performance of normal tasks associated with operating a commercial motor vehicle is subject to the Skill Performance Evaluation (SPE) Certification Program pursuant to Section 391.49, assuming the person is otherwise qualified.

With the advancement of technology, medical aids and equipment modifications have been developed to compensate for certain

disabilities. The SPE Certification Program (formerly the Limb Waiver Program) was designed to allow persons with the loss of a foot or limb or with functionai impairment to qualify under the Federal Motor Carrier Safety Regulations (FMCSRs) by use of prosthetic devices or equipment modifications which enable them to safely operate a commercial motor vehicle. Since there are no medical aids equivalent to the original body or limb, certain risks are still present, and thus restrictions may be included on individual SPE certificates when a State Director for the FMCSA determines they are necessary to be consistent with safety and public interest.

If the driver is found otherwise medically qualified (391.41(b)(3) through (13)), the medical examiner must check on the medical certificate that the driver is qualified only if accompanied by a SPE certificate. The driver and the employing motor carrier are subject to appropriate penalty if the driver operates a commercial motor vehicle in interstate or foreign commerce without a current SPE certificate for his/her physical disability.

Diabetes: 391.41(b)(3)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis for diabetes mellitus currently requiring insulin for control.

Diabetes mellitus is a disease which, on occasion, can result in a loss of consciousness or disorientation in time and space. Individuals who require insulin for control have conditions which can get out of control by the use of too much or too little insulin, or food intake not consistent with the insulin dosage. Incapacitation may occur from symptoms of hyperglycemic or hypoglycemic reactions (drowsiness, semiconsciousness, diabetic coma or insulin shock).

The administration of insulin is, within itself, a complicated process requiring insulin, syringe, needle, alcohol sponge and a sterile technique. Factors related to long-haul commercial motor vehicle operations, such as fatigue, lack of sleep, poor diet, emotional conditions, stress, and concomitant illness, compound the dangers. The FMCSA has consistently held that a diabetic who uses insulin for control does not meet the minimum physical requirements of the FMCSRs.

Hypoglycemic drugs, taken orally, are sometimes prescribed for diabetic individuals to help stimulate natural body production of insulin. If the condition can be controlled by the use of oral medication and diet, then an individual may be qualified under the present rule. CMV drivers who do not meet the Federal diabetes standard may call (202) 366-1790 for an application for a diabetes exemption.

NOTE: See Conference Report on Diabetic Disorders and Commercial Drivers and Insulin- Using Commercial Motor Vehicle Drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm

Cardiovascular Condition: 391.41(b)(4)

A person is physically qualified to drive a commercial motor vehicle if that person: *Has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse or congestive cardiac failure.*

The term "has no current clinical diagnosis of" is specifically designed to encompass: "a clinical diagnosis of" (1) a current cardiovascular condition, or (2) a cardiovascular condition which has not fully stabilized regardless of the time limit. The term *"known to* be accompanied by" is defined to include: a clinical diagnosis of a cardiovascular disease (1) which is accompanied by symptoms of syncope, dyspnea, collapse or congestive cardiac failure; and/or (2) which is likely to cause syncope, dyspnea, collapse or congestive cardiac failure.

It is the intent of the FMCSRs to render unqualified a driver who has a current cardiovascular disease which is accompanied by and/or likely to cause symptoms of syncope, dyspnea, collapse, or congestive cardiac failure. However, the subjective decision of whether the nature and severity of an individual's condition will likely cause symptoms of cardiovascular insufficiency is on an individual basis and qualification rests with the medical examiner and the motor carrier. In those cases where there is an occurrence of cardiovascular insufficiency (myocardial infarction, thrombosis, etc.) it is suggested before a driver is certified that he/she have a normal resting and stress electrocardiogram (ECG), no residual complications and no physical limitations, and is taking no medication likely to interfere with safe driving.

Coronary artery bypass surgery and pacemaker implantation are remedial procedures and thus, not unqualifying. Implantable cardioverter defibrillators are disqualifying due to risk of syncope. Coumadin is a medical treatment which can improve the health and safety of the driver and should not, by its use, medically disqualify the commercial driver. The emphasis should be on the underlying medical condition(s) which require treatment and the general health of the driver. The FMCSA should be contacted at (202) 366-1790 for additional recommendations regarding the physical qualifications of drivers on coumadin.

NOTE: See Conference on Cardiac Disorders and Commercial Drivers at http://www.fmcsa.dot.gov/rulesregs/medreports.htm.

Respiratory Dysfunction: 391.41(b)(5)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of a respiratory dysfunction likely to interfere with ability to control and drive a commercial motor vehicle safely.

Since a driver must be alert at all times, any change in his/her mental state is in direct conflict with highway safety. Even the lightest impairment in respiratory function under emergency conditions (when greater oxygen supply is necessary for performance) may be detrimental to safe driving.

There are many conditions that interfere with oxygen exchange and may result in incapacitation, including emphysema, chronic asthma, carcinoma, tuberculosis, chronic bronchitis and sleep apnea. If the medical examiner detects a respiratory dysfunction, that in any way is likely to interfere with the driver's ability to safely control and drive a commercial motor vehicle, the driver must be referred to a specialist for further evaluation and therapy. Anticoagulation therapy for deep vein thrombosis and/or pulmonary thromboembolism is not unqualifying once optimum dose is achieved, provided lower extremity venous examinations remain normal and the treating physician gives a favorable recommendation.

NOTE: See conference on pulmonary/respiratory disorders and commercial drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm.

Hypertension: 391.41(b)(6)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no current clinical diagnosis of high blood pressure likely to interfere with ability to operate a commercial motor vehicle.

Hypertension alone is unlikely to cause sudden collapse; however, the likelihood increases when target organ damage, particularly cerebral vascular disease, is present. This regulatory criteria is based on FMCSA's Cardiovascular Advisory Guidelines for the Examination of CMV Drivers, which used the Sixth Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (1997).

Stage 1 hypertension corresponds to a systolic BP of 140-159mmHg and/or a diastolic BP of 90-99mmHg. The driver with a BP in this range is at low risk for hypertension-related acute incapacitation and may be medically certified to drive for a one-year period. Certification examinations should be done annually thereafter and should be at or less than 140/90. If less than 160/100, certification may be extended one time for 3 months.

A blood pressure of 160-179 systolic and/or 100-109 diastolic is considered Stage 2 hypertension, and the driver is not necessarily unqualified during evaluation and institution of treatment. The driver is given a one time certification of three months to reduce his or her blood pressure to less than or equal to 140/90. A blood pressure in this range is an absolute indication for anti-hypertensive drug therapy. Provided treatment is well tolerated and the driver demonstrates a BP value of 140/90 or less, he or she may be certified for one year from date of the initial exam. The driver is certified annually thereafter.

A blood pressure at or greater than 180 (systolic) and 110 (diastolic) is considered Stage 3, high risk for an acute BP-related event. The driver may **not** be qualified, even temporarily, until reduced to 140/90 or less and treatment is well tolerated. The driver may be certified for 6 months and biannually (every 6 months) thereafter if at recheck BP is 140/90 or less.

Annual recertification is recommended if the medical examiner does not know the severity of hypertension prior to treatment.

An elevated blood pressure finding should be confirmed by at least two subsequent measurements on different days.

Treatment includes nonpharmacologic and pharmacologic modalities as well as counseling to reduce other risk factors. Most antihypertensive medications also have side effects, the importance of which must be judged on an individual basis. Individuals must be alerted to the hazards of these medications while driving. Side effects of somnolence or syncope are particularly undesirable in commercial drivers.

Secondary hypertension is based on the above stages. Evaluation is warranted if patient is persistently hypertensive on maximal or near-maximal doses of 2-3 pharmacological agents. Some causes of secondary hypertension may be amenable to surgical intervention or specific pharmacologic disease.

NOTE: See Cardiovascular Advisory Panel Guidelines for the Medical Examination of Commercial Motor Vehicle Drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm

Rheumatic, Arthritic, Orthopedic, Muscular, Neuromuscular or Vascular Disease: 391.41(b)(7)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease which interferes with ability to control and operate a commercial motor vehicle safely

Certain diseases are known to have acute episodes of transient muscle weakness, poor muscular coordination (ataxia), abnormal sensations (paresthesia), decreased muscular tone (hypotonia), visual disturbances and pain which may be suddenly incapacitating. With each recurring episode, these symptoms may become more pronounced and remain for longer periods of time. Other diseases have more insidious onsets and display symptoms of muscle wasting (atrophy), swelling and paresthesia which may not suddenly incapacitate a person but may restrict his/her movements and eventually interfere with the ability to safely operate a motor vehicle. In many instances these diseases are degenerative in nature or may result in deterioration of the involved area.

Once the individual has been diagnosed as having rheumatic, arthritic, orthopedic, muscular, neuromuscular or vascular disease, then he/she has an established history of that disease. The physician, when examining an individual, should consider the following: (1) the nature and severity of the individual's condition (such as sensory loss or loss of strength); (2) the degree of limitation present (such as range of motion); (3) the likelihood of progressive limitation (not always present initially but may manifest itself over time); and (4) the likelihood of sudden incapacitation. If severe functional impairment exists, the driver does not qualify. In cases where more frequent monitoring is required, a certificate for a shorter time period may be issued.

NOTE: See Conference on Neurological Disorders and Commercial Drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm

Epilepsy: 391.41(b)(8)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control a motor vehicle.

Epilepsy is a chronic functional disease characterized by seizures or episodes that occur without warning, resulting in loss of voluntary control which may lead to loss of consciousness and/or seizures. Therefore, the following drivers cannot be qualified: (1) a driver who has a medical history of epilepsy; (2) a driver who has a current clinical diagnosis of epilepsy; or (3) a driver who is taking anti-seizure medication.

If an individual has had a sudden episode of a non-epileptic seizure or loss of consciousness of unknown cause which did not require anti-seizure medication, the decision as to whether that person's condition will likely cause loss of consciousness or loss of ability to control a motor vehicle is made on an individual basis by the medical examiner in consultation with the treating physician. Before certification is considered, it is suggested that a 6 month waiting period elapse from the time of the episode. Following the waiting period, it is suggested that the individual have a complete neurological examination. If the results of the examination are negative and anti-seizure medication is not required, then the driver may be qualified.

In those individual cases where a driver has a seizure or an episode of loss of consciousness that resulted from a known medical condition (e.g. drug reaction, high temperature, acute infectious disease, dehydration or acute metabolic disturbance), certification should be deferred until the driver has fully recovered from that condition and has no existing residual complications, and not taking anti-seizure medication.

Drivers with a history of epilepsy/seizures off anti-seizure medication and seizure-free for 10 years may be qualified to drive a CMV in interstate commerce. Interstate drivers with a history of a single unprovoked seizure may be qualified to drive a CMV and interstate commerce if seizure-free and off anti-seizure medication for a 5 year period or more.

NOTE: See Conference on Neurological Disorders and Commercial Drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm

Mental Disorders: 391.41(b)(9)

A person is physically qualified to drive a commercial motor vehicle if the person:

Has no mental, nervous, organic or functional disease or psychiatric disorder likely to interfere with the ability to drive a motor vehicle safely.

Emotional or adjustment problems contribute directly to an individual's level of memory, reasoning, attention and judgment. These problems often underlie physical disorders. A variety of functional disorders can cause drowsiness, dizziness, confusion, weakness or paralysis that may lead to incoordination, inattention, loss of functional control and susceptibility to accidents while driving. Physical fatigue, headache, impaired coordination, recurring physical, ailments and chronic "nagging" pain may be present to such a degree that certification for commercial driving is inadvisable. Somatic and psychosomatic complaints should be thoroughly examined when determining an individual's overall fitness to drive. Disorders of a periodically incapacitating nature, even in the early stages of development, may warrant disqualification.

Many bus and truck drivers have documented that "nervous trouble" related to neurotic, personality, emotional or adjustment problems is responsible for a significant fraction of their preventable accidents. The degree to which an individual is able to appreciate, evaluate and adequately respond to environmental strain and emotional stress is critical when assessing an individual's mental alertness and flexibility to cope with the stresses of commercial motor vehicle driving.

When examining the driver, it should be kept in mind that individuals who live under chronic emotional upsets may have deeply ingrained maladaptive or erratic behavior patterns. Excessively antagonistic, instinctive, impulsive, openly aggressive, paranoid or severely depressed behavior greatly interfere with the driver's ability to drive safely. Those individuals who are highly susceptible to frequent states of emotional instability (schizophrenia, affective psychoses, paranoia, anxiety or depressive neuroses) may warrant disqualification. Careful consideration should be given to the side effects and interactions of medications in the overall qualification determination. See Psychiatric Conference Report for specific recommendations on the use of these medications and potential hazards for driving.

NOTE: See Conference on Psychiatric Disorders and Commercial Drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm

Vision: 391.41(b)(10)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has distant visual acuity of at least 20/40 (Snellen) in each eye with or without corrective lenses or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distance binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, green and amber.

The term "ability to recognize the colors of" is interpreted to mean if a person can recognize and distinguish among traffic control signals and devices showing standard red, green and amber, he or she meets the minimum standards, even though he or she may have some type of color perception deficiency. If certain color perception tests are administered, (such as Ishihara, Pseudoisochromatic, Yarn) and doubtful findings are discovered, a controlled test using signal red, green and amber may be employed to determine the driver's ability to recognize these colors.

Contact lenses are permissible if there is sufficient evidence to indicate that the driver has good tolerance and is well adapted to their use. Use of a contact lens in one eye for distance visual acuity and another lens in the other eye for near vision is not acceptable, nor are telescopic lenses acceptable for the driving of commercial motor vehicles.

If an individual meets the criteria by the use of glasses or contact lenses, the following statement shall appear on the Medical Examiner's Certificate: "Qualified only if wearing corrective lenses".

CMV drivers who do not meet the Federal vision standard may call (202) 366-1790 for an application for a vision exemption.

NOTE: See Visual Disorders and Commercial Drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm

Hearing: 391.41(b)(11)

A person is physically qualified to drive a commercial motor vehicle if that person:

First perceives a forced whispered voice in the better ear at not less than 5 feet with or without the use of a hearing aid, or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz, 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard (formerly ASA Standard) 224.5-1951

Since the prescribed standard under the FMCSRs is the American Standards Association (ANSI), it may be necessary to convert the audiometric results from the ISO standard to the ANSI standard. Instructions are included on the Medical Examination report form.

If an individual meets the criteria by using a hearing aid, the driver must wear that hearing aid and have it in operation at all times while driving. Also, the driver must be in possession of a space power source for the hearing aid.

For the whispered voice test, the individual should be stationed at least 5 feet from the examiner with the ear being tested turned toward the examiner. The other ear is covered. Using the breath which remains after a normal expiration, the examiner whispers words or random numbers such as 66, 18, 23, etc. The examiner should not use only sibilants (s-sounding test materials). The opposite ear should be tested in the same manner. If the individual fails the whispered voice test, the audiometric test should be administered.

If an individual meets the criteria by the use of a hearing aid, the following statement must appear on the Medical Examiner's Certification " Qualified only when wearing a hearing aid".

NOTE: See Hearing Disorders and Commercial Motor Vehicle Drivers at: http://www.fmcsa.dot.gov/rulesregs/medreports.htm

Drug Use 391.41(b)(12)

A person is physically qualified to drive a commercial motor vehicle if that person:

Does not use a controlled substance identified in 21 CFR 1308.11. Schedule 1, an amphetamine, a narcotic, or any other habit-forming drug. Exception: A driver may use such a substance or drug, if the substance or drug is prescribed by a licensed medical practitioner who is familiar with the driver's medical history and assigned duties; and has advised the driver that the prescribed substance or drug will not adversely affect the driver's ability to safely operate a commercial motor vehicle.

This exception does not apply to methadone. The intent of the medical certification process is to medically evaluate a driver to ensure that the driver has no medical condition which interferes with the safe performance of driving tasks on a public road. If a driver uses a Schedule I drug or other substance, an amphetamine, a narcotic, or any other habit-forming drug, it may be cause for the driver to be found medically unqualified. Motor carriers are encouraged to obtain a practitioner's written statement about the effects on transportation safety of the use of a particular drug.

A test for controlled substances is not required as part of this biennial certification process. The FMCSA or the driver's employer should be contacted directly for information on controlled substances and alcohol testing under Part 382 of the FMCSRs.

The term "uses" is designed to encompass instances of prohibited drug use determined by a physician through established

medical means. This may or may not involve body fluid testing. If body fluid testing takes place, positive test results should be confirmed by a second test of greater specificity. The term "habit-forming" is intended to include any drug or medication generally recognized as capable of becoming habitual, and which may impair the user's ability to operate a commercial motor vehicle safely.

The driver is medically unqualified for the duration of the prohibited drug(s) use and until a second examination shows the driver is free from the prohibited drug(s) use. Re-certification may involve a substance abuse evaluation, the successful completion of a drug rehabilitation program, and a negative drug test result. Additionally, given that the certification period is normally two years, the examiner has the option to certify for a period of less than 2 years if this examiner determines more frequent monitoring is required.

NOTE: See Conference on Neurological Disorders and Commercial Drivers Conference on Psychiatric Disorders and Commercial Drivers at: http://fmcsa.dot.gov/rulesregs/medreport.htm

Alcoholism: 391.41(b)(13)

A person is physically qualified to drive a commercial motor vehicle if that person:

Has no current clinical diagnosis of alcoholism.

The term "current clinical diagnosis of" is specifically designed to encompass a current alcoholic illness or those instances where the individual's physical condition has not fully stabilized, regardless of the time element. If an individual shows signs of having an alcohol-use problem, he/she should be referred to a specialist. After counseling and/or treatment, he or she may be considered for certification.

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined _____ in accordance with the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and with knowledge of the driving duties, I find this person is qualified; and, if applicable, only when:

_____ wearing corrective lenses

_____ wearing a hearing aid

_____ accompanied by a _____ waiver/exemption

_____ driving within an exempt intra-city zone (49 CFR 391.62)

_____ accompanied by a Skill Performance Evaluation (SPE) Certificate

_____ qualified by operation of 49 CFR 391.64 (vision or insulin dependent waiver program)

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachment embodies my findings completely and correctly and is on file in my office.

_____
Date of Examination

_____ Signature of Medical Examiner

_____ Telephone

_____ Expiration Date of Driver Certification

_____ Name of Medical Examiner (Print)

_____MD_____ DO_____Chiropractor _____ Physician Asst._____Advanced Practice Nurse

_____ Medical Examiner's Address

_____ Medical Examiner's License/Certificate #

_____ Issuing State

_____ Signature of Driver

_____ Driver's License Number

_____ State of License

_____ Driver's Name (Print)

_____ Driver's Address (City/State/Zip)

NOTE: DRIVER MUST CARRY A COPY OF THIS CERTIFICATE WHEN OPERATING A COMMERCIAL VEHICLE.

TRAINING PERIOD: _____

NAME OF TRAINEE: _____

ADDRESS: _____ PHONE #: _____

HAS / HAS NOT SUCCESSFULLLY COMPLETED (10) DAYS IN SCHOOL BUS DRIVING WITH: _____BUS #: _____

_____#6 Pre-Trip Inspection

_____#5 Emergency Drill

_____#1 Student Roster

_____#8 Mid-Year Inspection

_____#9 Mileage Sheet

_____#10 Trip Sheet

_____#14 Loss of Time

_____#13&13A Accident Report

_____#11 Discipline Reports

TRAINEE PROCEDURE

_____Loading Students

_____Unloading Students

_____Crossing Railroad Tracks

_____Backing on Streets

_____Backing on School Grounds

_____Accidents without Injuries

_____Accidents with Injuries

_____Discipline on bus going to School

_____Discipline on bus coming from School

_____Breakdowns going to School

_____Breakdowns coming from School

TRAINEE: _____

This Driver needs more training in: _____

_____

REMARKS: _____

_____

_____

DATE: _____ DRIVER TRAINER: _____ BUS #: _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-___		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

R-1300 (4/11)

LDR
Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "*No exemptions or dependents claimed*" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "*Single*" under number 3 below. if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "Single" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "Married" under number 3 below.

A.

Block B

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana Department of Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial	Last name
2. Social Security Number	**3.** Select one ☐ No exemptions or dependents claimed ☐ Single ☐ Married
4. Home address (number and street or rural route)	
5. City / State / ZIP	
6. Total number of exemptions claimed in Block A	**6.**
7. Total number of dependents claimed in Block B	**7.**
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.	**8.**

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date

The following is to be completed by employer.

9. Employer's name and address	**10.** Employer's state withholding account number

CPR/First Aid Certification:

ACADIANA SAFETY ASSOCIATION, INC.
1126 Coolidge Street
Lafayette, LA 70503
(337) 234-4640
www.acadianasafety.org

SOUTHWEST SAFETY TRAINING, INC.
4416 Johnston Street
Lafayette, LA 70503
(337) 989-0120
www.southwestsafetytraining.com

Defensive Driving Course (Bus Drivers Only):

Lanny Soudelier, Driving Instructor
lanny@consolidatedsafety.org
Consolidated Safety of Acadiana
148 Banks Ave.
Lafayette, LA 70506
(337) 504-5716
www.consolidatedsafety.org

CDL Physical Examinations:

Occupational Medicine – (337) 233-4480

Southwest Medical Center – (337) 988-8811

Acadian Health Services – (337) 234-9925

Youngsville Medical Clinic – (337) 837-3615