



STATE OF MINNESOTA
DEPARTMENT OF PUBLIC SAFETY

HOW DO I OBTAIN A VISION WAIVER TO DRIVE A SCHOOL BUS OR TYPE III SCHOOL BUS IN MINNESOTA?

Step 1:

If you have not already done so, you must have a medical examination by a licensed physician at some point within the two years preceding the date of application to assure that you have no other disqualifying medical conditions. The complete medical examination must include a review of all items listed in Code of Federal Regulations, title 49, section 391.41. Include a copy of the **MEDICAL EXAMINATION REPORT - for Commercial Driver Fitness Determination** with your waiver application.

Step 2:

Complete the attached **School Bus and Type III School Bus Driver Medical Waiver Application**.

Step 3:

Submit **one** of the following:

- 1) A legible copy of both sides of your current commercial driver's license.
- 2) A legible copy of both sides of the license you last possessed to operate a commercial motor vehicle.
- 3) A certification from the State licensing agency showing the type and effective date of the most recent license you have held.

Step 4:

Complete the attached **Vision Waiver Application**.

Step 5:

You must have an eye examination performed by an **Optometrist or Ophthalmologist** and attach the **Optometrist or Ophthalmologist Report** dated within the past six months.

After these steps have been completed, forward all of the application information for the vision waiver to the above address. The information will be reviewed and you will be notified of the department's decision by mail. If a waiver is issued, you must comply with its terms and conditions.

Incomplete applications will be returned and may result in a waiver not being issued.



School Bus and Type III School Bus Driver Medical Waiver Application

Print this completed form. This form can be mailed or submitted in person to Driver and Vehicle Services, 445 Minnesota Street, St. Paul, Minnesota 55101-5180. It may also be faxed to (651) 297-4447.

- This application is to be used for waiver requests of the requirements in [Minnesota Rules 7414.1200](#) and [Code of Federal Regulations, title 49, section 391.41](#).
- Additional application information and forms must be completed if the condition involves a limb impairment, insulin-dependent diabetes, or vision. No waiver is granted for the hearing requirement.
- **Incomplete applications will be returned and may result in a waiver not being issued.**
- Attach additional information as needed.

I am applying for a waiver of the medical condition described in this application, as provided for in [Minnesota Rule 7414.1410](#). Except for the condition described herein, I am otherwise medically qualified to operate a school bus or Type III school bus within the state.

A Driver Applicant Information

Full Name _____ Date of Birth (mm/dd/yy) _____

Street Address _____ City / State / Zip Code _____

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Driver's License Number _____ License Expiration Date (mm/dd/yy) _____

Daytime Phone (INCLUDE AREA CODE) _____ E-mail Address _____

B Medical Condition Information

1. Specify the physical qualifications for which a waiver is requested.

2. Describe your disability or impairment.

3. Describe the school bus or Type III school bus you intend to drive, including passenger capacity and gross vehicle weight, if known.

4. Estimate the period of time, per day, that you will be driving and on duty.

5. Provide your driving record for the last three years, including driving records from other states, if applicable.

6. Provide the medical examination performed according to Minnesota Rules part 7414.1200 and Code of Federal Regulations, title 49, section 391.41 -- and a copy of the certificate from the examining physician attesting that you are otherwise qualified, except for the disability or impairment for which a waiver is requested.

7. Provide a copy of your road test as prescribed by Driver and Vehicle Services.

8. Describe the alternative measures; modification of policies, practices, or procedures; or the provision of auxiliary aids or services that will be taken to ensure there is no significant risk to the health and safety of the public and pupils, should the waiver be granted.

X

Waiver Applicant's Signature

Date (mm/dd/yy)

Attach additional information as needed



Vision Waiver Application

Print this completed form. This form can be mailed or submitted in person to Driver and Vehicle Services, 445 Minnesota Street, St. Paul, Minnesota 55101-5180. It may also be faxed to (651) 297-4447. If you have questions or need additional information, please contact DVS at (651) 297-5029 or (651) 282-6555 (TTY).

- This application is to be used for a waiver request of the requirements in [Minnesota Rules 7414.1200](#) and [Code of Federal Regulations, title 49, section 391.41](#).
- Except for the vision impairment described herein, I am otherwise medically qualified to operate a school bus or Type III school bus within the state.
- **Incomplete applications will be returned and may result in a waiver not being issued.**
- Attach additional information as needed.

A Driver Applicant Information

Full Name

Date of Birth (mm/dd/yy)

Street Address

City / State / Zip Code

- - - -

Driver's License Number

License Expiration Date (mm/dd/yy)

Daytime Phone (INCLUDE AREA CODE)

E-mail Address

B Vision Condition Information

I had an eye examination performed by an **Optometrist or Ophthalmologist** within the past six months. Attached is the **Optometrist or Ophthalmologist Report** that:

1. Identifies my visual deficiency.
2. Certifies that my visual acuity is at least 20/40 Snellen, corrected or uncorrected, in the better eye.
3. Certifies that my field of vision is no less than 120 degrees in one or both eyes together as demonstrated on a Goldman perimeter using an IIIe target, or equivalent full field test using an automated perimeter.
4. Certifies that I recognize the colors of red, green, and amber in traffic signals in an actual field test if I failed a color screening test or comparable color contrast sensitivity test.
5. In the opinion of the optometrist or ophthalmologist, I can safely perform the required normal school bus or Type III school bus driver operations.

The information I have provided on this application is true and accurate to the best of my knowledge.

X
Waiver Applicant's Signature

Date (mm/dd/yy)



MINNESOTA DEPARTMENT OF PUBLIC SAFETY

Driver and Vehicle Services
445 Minnesota Street, Suite 180
St. Paul, MN 55101-5180

Phone: (651) 296-6911 Fax: (651) 282-2463 TTY: (651) 282-6555
Web: dvs.dps.mn.gov

Vision Report

- Section A - (Reverse Side) Must be completed and signed by patient in the presence of the vision examiner
- Section B - (Reverse Side) Must be completed and signed by a licensed vision examiner
- Minnesota statutes may require driving restrictions other than those recommended by the licensed vision examiner
- Submit the form:
 - By mail: send to the address listed above
 - By Fax: (651) 282-2463
 - In person: Bring to any [Driver's License Exam Station](#)

DATA PRIVACY

All the information collected on this form is required by law. This data is used by authorized Driver and Vehicle Services division personnel to ensure that those with insufficient vision take the steps required to achieve the best vision possible and to deny driving privileges to those whose vision is likely to interfere with the safe operation of motor vehicles. (Minnesota Statutes, chapters 171.04, 171.13, and 171.14; Minnesota Rule 7410.2400)

All data collected on this form is private and may not be issued to anyone, with the exception of name and address, which may be provided to law enforcement personnel.

A driver's license will not be issued until a satisfactory report is submitted.

Restriction Information - For complete information see Minnesota Rule 7410.2400

- **Daylight Restriction:** Visual acuity of 20/50 or less may be restricted to daylight hours.
- **Speed Restriction:** Visual acuity of 20/50 or less corrected vision in one usable eye or both eyes, or visual field of less than 105 degrees. *20/50: 55 miles per hour 20/60: 50 miles per hour 20/70: 45 miles per hour*
- **Area Restriction:** Visual acuity of 20/50 or less may be restricted to driving within a certain area equal to or less than the speed restriction. For example, a person limited to a maximum speed of 45 miles per hour or less is prohibited from driving on any freeway, expressway, or limited access highway that has a speed limit of more than 45 miles per hour.
- **Road Restriction:** Drivers with speed restrictions may also be restricted to driving on roads that have a speed limit.
- **Equipment Restriction:** Field of vision less than 105 degrees in the horizontal diameter with either one usable eye or with both eyes - requires left and right outside rearview mirrors on vehicle.



SECTION A - TO BE COMPLETED BY PATIENT (Please Print)

MINNESOTA DRIVER'S LICENSE NUMBER:

____ - ____ - ____ - ____ - ____

BIRTH DATE:

____ / ____ / ____

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Patient's Signature (MUST be signed in the presence of the vision examiner).

SECTION B - TO BE COMPLETED BY LICENSED VISION EXAMINER

Peripheral Vision

Horizontal Fields in Degree

Date of Last Vision Exam

Must have been within six months:

____ / ____ / ____

Right Eye:	
Left Eye:	
Both Eyes:	

Vision Acuity

	Without Corrective Lenses	With Present Corrective Lenses	With New Corrected Lenses
Right Eye:	20/	20/	20/
Left Eye:	20/	20/	20/
Both Eyes:	20/	20/	20/

Is your patient's vision adequate to exercise reasonable and proper control of a motor vehicle? (Please check one)

No, reason: _____

Yes, without corrective lenses

Yes, with present corrective lenses

Yes, with new corrective lenses

Do you feel your patient would be safe driving in an area limited to familiar surroundings? NO YES

Should your patient be required to have periodic visual exams? NO YES If yes, how often? _____

Recommended Restrictions: Please mark all that apply.

Daylight Only _____ Maximum Speed _____ mph Limit to _____ miles from home No Freeway Driving _____

Other (Specify) _____

VISION PROBLEMS

Please identify any condition that is impairing your patient's vision (i.e., cataracts present, macular degeneration, diabetic retinopathy, peripheral vision impairment, etc.). _____

What affect does your patient's condition have on his/her ability to see while driving? (i.e., tunnel vision, blurred vision, blank spots, etc.? _____

The condition is (please check one): STABLE PROGRESSIVE

If your patient's vision is 20/80 or up to but not including 20/100, please answer following questions:

Is there treatment that would improve your patient's vision? NO YES

Has treatment been scheduled? NO YES Anticipated date when treatment will be complete: ____ / ____ / ____

Vision Examiner's Name: _____ License Number: _____

Office Address: _____ Phone Number: _____

Street City State Zip Code

Vision Examiner's Signature Date

Vision Examiner's Signature

Date



Optometrist's/Ophthalmologists' Report of Vision Impairment

This completed form can be mailed or submitted in person to Driver and Vehicle Services, 445 Minnesota Street, St. Paul, Minnesota 55101-5180. It may also be faxed to (651) 297-4447. If you have questions or need additional information, please contact DVS at (651) 297-5029 or (651) 282-6555 (TTY).

Patient Name (PRINT)

Examination Date (mm/dd/yy)

- - - -

Patient's Driver's License Number

Dear Licensed Optometrist/Ophthalmologist:

The patient before you is applying for a waiver from vision-related medical criteria* in order to operate a school bus or Type III school bus within the state. We are asking your cooperation to examine this patient in accordance with this criteria, which is required by state law and administrative rule. All criteria below must be addressed. Please certify that you can complete this report by placing your signature and today's date at the bottom.

*Criteria is stipulated in [Code of Federal Regulations, title 49, section 391.41](#), paragraph (b) (10) and [Minnesota Rules, section 7414.1200](#).

1) Please identify, and define, the visual deficiency.

2) Yes No The patient's visual acuity is at least 20/40 (Snellen), corrected or uncorrected, in the better eye.

3) Yes No The applicant's field of vision is no less than 120 degrees in one or both eyes together as demonstrated on a Goldman perimeter, using an Ille target or equivalent field test that uses an automated perimeter.

4) Yes No The applicant recognizes the colors of red, green, and amber in traffic signals in an actual field test, if he or she fails a color screening test or comparable color contrast sensitivity test.

5) Yes No In my opinion, the patient can safely perform the normal required school bus or Type III school bus driver operations.

6) The length of time that the vision waiver is valid (*check one*):

Two years from date of last physical

Other (as determined by physical). Please list waiver ending date: _____

Licensed Optometrist's/Ophthalmologist's Name (PLEASE PRINT OR TYPE)

Office or Clinic Name

Daytime Phone (INCLUDE AREA CODE)

X
Physician Signature

Date (mm/dd/yy)