ARTICLE 19-A BUS DRIVER'S BLOOD PRESSURE FOLLOW-UP BY DRIVER'S HEALTH CARE PROVIDER

NYS DMV COMMISSIONER'S REGULATIONS PART 6.10

NOTE: This form may be used in conjunction with the *Examination to Determine Medical Condition of Driver Under Article 19-A* (DS-874), or with the federal medical form if it is being used in lieu of the DS-874.

BUS DRIVER'S NAME: _____
(Must correspond to name on driver's license)

DATE OF BIRTH: _____

CLIENT/LICENSE ID NUMBER (from Driver License): _____

I, _____, am acting as the above-
(Print Health Care Provider's Name)

named bus driver's health care provider. He/she is under my care, monitoring, and treatment (if necessary), for high blood pressure. His/her condition is controlled by (indicate which):

- ☐ Diet
- ☐ Medication (identify): _____
- ☐ Other means (explain): _____

Health Care Provider's License or Certificate Number _____ Issuing State_____

Health Care Provider's Address: _____

_____

Health Care Provider's Phone:_____

His/her blood pressure reading today is: Systolic: _____

Diastolic: _____

Health Care Provider's Signature ➧ _____

Date _____