Department of Motor Vehicles

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. The bus driver is under my care, monitoring, and treatment (if necessary), for high blood pressure. The bus driver's 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: _____

The bus driver's blood pressure reading today is: Systolic: _____

Diastolic: _____

Health Care Provider's Signature X _____

Date _____