TEXAS MEDICAL ADVISORY BOARD

Release Authorization for School Bus Drivers

(For use when requesting review)

TO SCHOOL BUS DRIVER APPLICANT:

I hereby authorize Dr. ______________________________ to give any examination he/she deems necessary for the purpose of determining my fitness to operate a school bus for the transportation of school pupils. I also authorize any other physicians who have attended me, or any hospital or clinic in which I may have been treated, to give the Texas Department of Health any information they may request concerning my condition.

I understand that this authorization includes permission for the Texas Department of Health to have this information reviewed by the Medical Advisory Board for the purpose of giving a medical opinion on my physical and/or mental capabilities to safely operate a school bus.

I also understand that I am to pay any professional fees or charges connected with this examination.

	______________________________ Printed Name of Applicant
NOTE: Physicians signature is required as acknowledgement that he/she has completed medical examination report.	______________________________ Mailing Address
	______________________________ City State Zip Code
	______________________________ (Area Code) Daytime Phone Number
______________________________ Printed Name of Physician	______________________________ Name of Employing School District
______________________________ Signature of Physician	______________________________ Signature of Applicant
______________________________ State Board Number Specialty	______________________________ Date