**Forms/Waivers/Restriction V**

Pursuant to KDE 702 KAR 5:080

Please confirm that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ received a complete physical for \_\_\_\_\_\_\_ year(s) and was not issued any of the following to support the medical certificate.

\*\***This form shall ONLY be completed by the DISTRICT and emailed if any of the areas below apply. This document shall be destroyed or maintained in a secure PII protected location.**

**Forms Yes**

Insulin Treated Diabetes

FMCSA 5870 \_\_\_\_

**Federal Exemptions**

* Vision (form #5871) \_\_\_\_
* Hearing (FMCSA application package) \_\_\_\_
* Seizure (FMCSA application package) \_\_\_\_
* Stroke (FMCSA application package) \_\_\_\_
* FMCSA SPE Certificate application \_\_\_\_

**Or Federal Waivers**

* Restriction V \_\_\_\_

This form shall be transmitted directly to the school district or KYTC from the provider by email and/or fax and all accompanying forms/waivers/exemptions or restrictions shall be emailed to [KYTC.CDLwaivers@ky.gov](mailto:KYTC.CDLwaivers@ky.gov) or faxed to 502-696-5899. Do not submit any other documentation as it will not be processed.

Provider Name Printed ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date sent to District\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Sent via Fax to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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