



Application for a School Pupil Transportation (7D) Certificate

Save time, go to Mass.gov/RMV/7D to apply online!
 Registry of Motor Vehicles • Vehicle Safety & Compliance Services
 P.O. Box 55892 • Boston MA 02205-5892

IMPORTANT: This application must be completed, signed, and dated. Incomplete applications will be returned.

A. Checklist

Resident Application:

- ✓ Application must be filled out completely.
- ✓ Application must be signed by the applicant and a current email address **must** be provided for future RMV correspondence.
- ✓ **NEW training requirements:**
 - ✓ Two hours of pre-service training.
 - ✓ All pre-service training must be completed **before** submitting the application.
 - ✓ For a list of training sessions, go to Mass.gov/RMV/7D.
- ✓ Fees: \$15.00 for one-year certificate; \$7.50 for six-month certificate.
 - ✓ Enclose check or money order payable to MassDOT.
- ✓ Only original forms are accepted (no copies).
- ✓ The transportation company that you are employed by, or expect to be employed by, must complete section B – Applicant Information.
- ✓ Any applicant who has ever resided in another state or country and has relocated to Massachusetts must include with application:
 - ✓ **Certified** Out-of-State Driving Record effective within the preceding 90 days of application submission.
 - ✓ **Certified** Out-of-State Criminal Record Report effective within the preceding 90 days of application submission.

CORI Form:

- ✓ CORI must be filled out completely **and notarized**.
- ✓ CORI must accompany your application.

Medical Requirements:

- ✓ Applicant's medical exam must be conducted and dated within the preceding 90 days of application submission. See section G – Patient Information.

Current Out of State Applicant:

- ✓ Include **Certified** Out-of-State Driving Record effective within the preceding 90 days of application submission. Screen prints are **not** accepted.
- ✓ Include **Certified** Out-of-State Criminal Record Report effective within the preceding 90 days of application submission.

Mail complete application to: Registry of Motor Vehicles
 Vehicle Safety and Compliance Services, Attn: 7D
 P.O. Box 55892
 Boston, MA 02205-5892

An incomplete application will be returned. Save a copy of all submitted forms.

For questions, email SchoolBus7DNotify@state.ma.us or call Vehicle Safety and Compliance Services at 857-368-7310. For more information, go to Mass.gov/RMV/7D.

B. Applicant Information

| | | | | | | | | | | | | | | | |
|--|--|-------------------|--|--------------------------------------|--|------|--|---|--|-------|--|---|--|--|--|
| Last Name | | | | First Name | | | | Middle Name | | | | Suffix | | | |
| Date of Birth (MM/DD/YYYY) / / | | | | Driver's License # | | | | Social Security Number - - | | | | Gender <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| License Class | | State of Issuance | | Expiration (MM/DD/YYYY) / / | | | | | | | | | | | |
| Residential Address (Where you actually reside) | | | | | | | | | | | | | | | |
| Street | | | | Apt. # | | City | | | | State | | Zip Code | | | |
| Mailing Address <input type="checkbox"/> (same as above) | | | | | | | | | | | | | | | |
| Street | | | | Apt. # | | City | | | | State | | Zip Code | | | |
| Email | | | | | | | | Phone Type <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | | | Phone # | | | |

Employer Information

| | | | | |
|----------------|---|------|---------|----------|
| Employer Name | Address Street | City | State | Zip Code |
| Employer Email | Phone Type <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work | | Phone # | |

C. Certificate Type

- One -year - \$15
- 6-Month - \$7.50 - Applicants who are over 70 years of age and are insulin-dependent, diabetic, or have had a hypoglycemic episode.

D. Pre-Service Training Requirement

An applicant for a school pupil transport operator shall complete a minimum of two hours of pre-service training as established and approved by the Registrar **prior** to receiving the certificate. FOR SCHOOL PUPIL TRANSPORT CERTIFICATION, a trainer or designated person must sign below in accordance with the requirements of **M.G.L. Chapter 90, Section 804(1)**.

| | |
|--|---|
| Trainer or Designated Person | Trainer's License # |
| Email Address | Phone # |
| Signature of Trainer or Designated Person: | Total Driver Pre-Service Training Hours |

E. Certification and Applicant Signature

I have reviewed this completed **Application** and swear (affirm), under the penalties of perjury, that the information I have provided is true and correct.

I am aware that false statements are punishable by fine, imprisonment, or both under M.G.L. Chapter 90, Section 24B.

Applicant's Signature: _____ Date: _____

F. Medical Information and Applicant Signature

I hereby authorize the Licensed Physician completing this form to discuss and release any or all medical records pertaining to its content with or to representatives of the Registry of Motor Vehicles.

Applicant's Signature _____ Date _____

G. Patient Information – Must be completed by a Licensed Physician, NOT a Nurse Practitioner or Physician Assistant.

| | | | |
|-----------------------------------|--------------------|-------------|--------|
| Last Name | First Name | Middle Name | Suffix |
| Date of Birth (MM/DD/YYYY) / / | Driver's License # | | |

1. Is the applicant currently diagnosed with having diabetes? Yes No
 - Is the applicant insulin dependent? Yes No
 - Has applicant ever had a hypoglycemic episode or spell? Yes No

If "YES" to either above, the applicant must submit a "Diabetes Medical Evaluation Form" completed by a Board Certified or Board eligible medical doctor in Endocrinology.
2. Does the applicant have an **Implanted Cardiac Defibrillator**? Yes No

If "YES" the applicant must submit a "Cardiovascular Medical Evaluation Form" completed by a medical doctor.

3. **Distant Visual Acuity (Snellen):** Left eye: (OS)20/ _____ Right eye: (OD) 20/ _____
- Does the applicant use corrective lenses for driving?..... Yes No
(If applicant uses corrective lenses for driving, please specify visual acuity above as corrected with Rx)
- Combined horizontal peripheral field of vision must be **NOT LESS THAN 120** combined (Record in degrees.):
- Is the applicant able to distinguish the colors red, green and amber? Yes No
4. **Hearing:** Can the applicant perceive a forced **whispered voice** in the better ear at not less than 5feet with or without the use of a hearing aid or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than **40 decibels** at 500Hz, 1000 Hz, and 2000Hz with or without a hearing aid when the audiometric device is calibrated to the American National Standard? Yes No
5. Does the applicant have a **Respiratory Disease/Disorder?** Yes No
If "YES" does the applicant have an O2 saturation rate of greater than 88%, at rest or with minimal exertion, with or without supplemental oxygen?..... Yes No
6. Is the applicant currently diagnosed with **Epilepsy?**..... Yes No
7. Does the applicant have any **loss or impairment** of foot, leg, finger, hand, or arm likely to interfere with safe driving? Yes No
8. Does the applicant have any other physical condition likely to interfere with safe driving? Yes No
9. Does the applicant have any **mental, nervous, organic, or functional disease** likely to interfere with safe driving? Yes No
10. Does the applicant have any **contagious or communicable diseases?**..... Yes No
11. Is the applicant addicted to the use of **narcotics** or habit forming or **tranquilizers** or **stimulants** or the excessive use of **alcoholic beverages** or **liquors?**..... Yes No
12. Please check ONE BOX below:
- The patient named above IS medically qualified to operate a school pupil transport vehicle and fulfill all of the duties and responsibilities associated with such operation.**
- The patient named above IS NOT medically qualified to operate a school pupil transport vehicle.**

Additional Comments: _____

| H. Physician Information and Attestation | | | |
|---|-------------------|-------------|----------|
| Massachusetts NPI # | | | |
| Last Name | First Name | Middle Name | |
| Phone # | Address Street | City/Town | Zip Code |
| Email | | | |

I hereby certify that the information provided herein is true, accurate and complete:

Physician's Signature _____ Date: _____



Criminal Offender Record Information (CORI) Acknowledgment Form

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 |



To be used by organizations conducting CORI checks for employment or licensing purposes.

The Massachusetts Registry of Motor Vehicles is registered under the provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, or current licensees.

As a prospective or current employee, subcontractor, volunteer, license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to DCJIS. I hereby acknowledge and provide permission to the Massachusetts Registry of Motor Vehicles to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Massachusetts Registry of Motor Vehicles with written notice of my intent to withdraw consent to a CORI check.

I also understand, that the Massachusetts Registry of Motor Vehicles may conduct subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature of CORI Subject

Date



Criminal Offender Record Information (CORI) Acknowledgment Form

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 |



A. Applicant Information

Please complete this section using the information of the person whose CORI you are requesting. The fields marked with an asterisk (*) are required.

| | | | | | |
|---|-----------------------|----------------|---------------------|---|----------|
| *First Name | | *Last Name | | Middle Name | Suffix |
| Former Last Name #1 | | | Former Last Name #2 | | |
| Former Last Name #3 | | | Former Last Name #4 | | |
| *Date of Birth (MM/DD/YYYY) / / | | Place of Birth | | *Last SIX digits of Social Security Number (SSN)? - <input type="checkbox"/> No SSN | |
| Gender <input type="checkbox"/> M <input type="checkbox"/> F | Height (feet, inches) | Eye Color | | | Race |
| Driver's License of ID Number | | | State of Issue | | |
| Father's Full Name | | | Mother's Full Name | | |
| Current Address | | | | | |
| * Residential Address (Where you actually reside) | | | | | |
| Street | | Apt. # | *City | *State | Zip Code |

B. Notarization Section – this section must be completed by a notary public

"On this ____ day of _____, 20 __, before me, the undersigned notary public, _____
(name of applicant) personally appeared, proved to me through satisfactory evidence of identification, which were
_____, to be the person who signed the preceding or attached document in my presence and who swore or
affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) knowledge and belief.

Seal of Notary Public

Notary Public Signature _____

Commonwealth of Massachusetts

County of _____

Commission Expires: _____