

Driver Training School Personnel Physical Examination

NAME			PHONE #		
ADDRESS		CITY	STATE	ZIP CODE	
SOCIAL SECURITY #		DATE OF BIRTH		AGE	
SEX	HEIGHT	WEIGHT	HAIR	EYES	

To be Completed by Physician

The person named above is applying for a driver training school instructor license and is required by law to submit a physical examination upon request. Please complete this form in full and return it to the applicant.

HEALTH HISTORY					
Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, fainting
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disease
<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease

If answer to any of the above is yes, please explain:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Vision abnormalities or eye disease (not correctable by eyeglasses)
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease (e.g., stroke, angina, heart failure, hypertension)
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease (e.g., emphysema, asthma)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus and/or other endocrine disorders
<input type="checkbox"/>	<input type="checkbox"/>	Impairment due to alcohol or drugs
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Heart and/or circulatory system disorder
<input type="checkbox"/>	<input type="checkbox"/>	Hearing abnormality
<input type="checkbox"/>	<input type="checkbox"/>	Restricted use of any extremity
<input type="checkbox"/>	<input type="checkbox"/>	Speech defect that would prevent giving clear directions or commands
<input type="checkbox"/>	<input type="checkbox"/>	Physical, mental, emotional condition which would affect ability to instruct others in the operation of a motor vehicle
<input type="checkbox"/>	<input type="checkbox"/>	Any communicable disease
<input type="checkbox"/>	<input type="checkbox"/>	Presently on medication - state reason and possible side effects:

Would present medication affect the person's ability to instruct student?

Comments:

I, the undersigned physician, found nothing during the examination of the applicant that would interfere with his/her duties as a driving instructor. I will approve him/her as physically fit to be a driver training instructor.

PHYSICIAN SIGNATURE X	PHYSICIAN NAME (PRINTED)	DATE
STREET ADDRESS	CITY	ZIP CODE
		PHONE #