



**DRIVER TRAINING SCHOOL PERSONNEL  
PHYSICAL EXAMINATION**

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

4501-7-05 (D)(9) "The Driver Training Personnel Physical Examination" shall be signed by a physician, nurse practitioner, or physician's assistant acting within their scope of practice declaring that the instructor does not have a medical condition, physical condition, including vision impairment (not corrected), which could interfere with the responsibilities of being an instructor or could jeopardize the health and welfare of students and/or general public.

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		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries	<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>

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)
<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"/>	Hypertension/Hypotension
<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:

**NOTE:** Driver Training Instructors may be required to provide training in a one-on-one setting behind the wheel of a vehicle with a student. DT instructor must be capable of reacting quickly to student errors to prevent crashes during behind-the-wheel instruction, and the instructor may be subjected to stressful situations both when instructing in a classroom and behind the wheel.

WOULD PRESENT MEDICATION AFFECT THE PERSON'S ABILITY TO INSTRUCT STUDENT?

COMMENTS

**MEDICAL PROFESSIONAL CERTIFICATION: (Please check the appropriate boxes)**

I, the undersigned medical professional,  found nothing /  found something during the examination of the applicant that would interfere with his/her duties as a driving instructor. I  will /  will not approve him/her as physically fit to be a driver training instructor.

MEDICAL PROFESSIONAL SIGNATURE	MEDICAL PROFESSIONAL NAME (PRINTED)	DATE
<b>X</b>		
STREET ADDRESS	CITY	ZIP CODE
		PHONE #