OHIO DEPARTMENT OF PUBLIC SAFETY

DRIVER TRAINING SCHOOL PERSONNEL PHYSICAL EXAMINATION

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

THIS FORM MUST BE COMPLETED BY A MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHIC MEDICINE.

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	
☐	☐	Asthma	☐	☐	Any other nervous disorder
☐	☐	Psychiatric disorder	☐	☐	Tuberculosis
☐	☐	Extensive confinement by illness or injury	☐	☐	Seizures, fits, convulsions, fainting
☐	☐	Kidney	☐	☐	Suffering from any other disease
☐	☐	Head or spinal injuries	☐	☐	Muscular disease

IF ANSWER TO ANY OF THE ABOVE IS YES, PLEASE EXPLAIN

YES	NO	
☐	☐	Vision abnormalities or eye disease (not correctable by eyeglasses)
☐	☐	Cardiovascular disease (e.g., stroke, angina, heart failure)
☐	☐	Respiratory disease (e.g., emphysema, asthma)
☐	☐	Diabetes mellitus and / or other endocrine disorders
☐	☐	Impairment due to alcohol or drugs
☐	☐	Hypertension / Hypotension
☐	☐	Heart and / or circulatory system disorder
☐	☐	Hearing abnormality
☐	☐	Restricted use of any extremity
☐	☐	Speech defect that would prevent giving clear directions or commands
☐	☐	Physical, mental, emotional condition which would affect ability to instruct others in the operation of a motor vehicle
☐	☐	Any communicable disease
☐	☐	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 accidents 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

DOCTOR CERTIFICATION: (Please check the appropriate boxes)

I, the undersigned physician, ☐ 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.

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