DRIVER INSTRUCTOR APPLICATION

MV3112 5/2011 s.343.62 Wis. Stats.

Driver Training School Coordinator
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Wisconsin Department of Transportation
Division of Motor Vehicles
WisDOT Driver Training School Program
PO Box 7920
Madison, WI 53707-7920

Section A - Customer - please print

Application Type – check one

- ☐ Original
- ☐ Renewal
- ☐ Duplicate – complete front only

License Type - check all that apply

- ☐ Adult only
- ☐ Adults and under 18
- ☐ Under 18 only
- ☐ Commercial motor vehicle (CMV)

Reason for duplicate: ____________________

* The social security number may be used for purposes authorized by law.

Neatness and accuracy are important since your license will be prepared from the information supplied on this application.

1. Applicant Name (First - Middle Initial - Last)			2. Social Security Number *	
3. Current Residence Address	City	ZIP Code	4. Birth Date	5. Sex
6. Mailing Address and/or Post Office Box - ONLY if Different from Residence				
7. Current Instructor ID Number	8. Driver License Number	9. Expiration Date	10. State of Issuance	

11. Are you a WisDOT employee? ☐ No ☐ Yes - Give Division and Bureau:

12. List all driving schools where you will instruct. For each driving school, include ID number, complete address, and telephone number. Attach a separate page if more space is needed.

YES	NO	
☐	☐	13. In the past 5 years, have you been licensed in another state or Canada? If yes, list location and submit a driving record from there.
☐	☐	14. Have you been associated with a driver school when its license was revoked, suspended, cancelled or denied? If yes, give school name, reason, date and location.
☐	☐	15. Are you employed by, or do you have financial interest in a third party tester for CMV? If yes, give third party tester name, address and telephone number.
☐	☐	16. In the past, have you been convicted of a felony? If yes, give reason, date and location.
☐	☐	17. Are you required to register with the Sex Offender Registry? If yes, give reason, date and location.
☐	☐	18. Are you required to register with the Nurse Aide Registry? If yes, give reason, date and location.
☐	☐	19. Have you had any instructor license revoked, suspended, cancelled, or denied? If yes, give reason, date and location.
☐	☐	20. In the past year, have you had a loss of consciousness or muscle control, caused by any of the following conditions? If yes, check condition(s) and give date.____________ ☐ Traumatic Brain or Head Injury ☐ Heart ☐ Mental ☐ Seizure Disorder ☐ Diabetes ☐ Lung ☐ Muscle or Nerve ☐ Stroke

21. I have completed one of the following training programs. Attach copies. (If applying for renewal or duplicate, disregard this question.)

☐ 40 Hour Course ☐ DPI Certification ☐ 9 Credits in Driver Education

22. For renewal only: I have completed the required traffic safety workshop.

☐ Yes, give date: ☐ No

23. I certify that the answers and statements on this application are true and correct. I understand that I may be required to submit additional medical information if requested. I also understand that this application will be denied if I have unpaid taxes or child support. I authorize the examining physician to release my medical history upon request to the Wisconsin Department of Transportation.

(Applicant Signature) (Date)

(Over)

Section B – Health Care Practitioner - please print

Please answer ALL of the following questions regarding the applicant identified on the other side of this form.

This report must be based on an examination conducted within the previous 24 months of this application.

Examination Date - Required

YES	NO		YES	NO		YES	NO	
☐	☐	Alcohol or other drug abuse or dependency within the past 12 months	☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date:_____	☐	☐	Loss of, or altered consciousness Date:_____
☐	☐	Alcohol or other drug abuse or dependency within the past 12 - 24 months Controlled by treatment? ☐ Yes ☐ No	☐	☐	Kidney disease, dialysis	☐	☐	Seizures, epilepsy Episode Date:_____
			☐	☐	Diabetes or elevated blood sugar controlled by ☐ Diet ☐ Pills ☐ Insulin	☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Positive TB in a communicable form				☐	☐	Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
☐	☐	Heart disease or heart attack, stroke, other cardiovascular condition	☐	☐	Lung disease, emphysema, asthma, chronic bronchitis	☐	☐	Blood pressure over 180/105
						☐	☐	Missing or impaired hand, arm, foot, leg
			☐	☐	Required oxygen use	☐	☐	Mental/Emotional Functions

For any YES answers, indicate onset date, diagnosis, and any current limitations. List all medications (including over-the-counter medications) used regularly or recently. _____

YES	NO	
☐	☐	The individual who is requesting this physical is applying to become a licensed driver training school instructor. In a vehicle, he/she may be instructing, at the same time, up to 3 students that may be under the age of 18. Do you believe this person is physically and mentally capable to act as a driver instructor?

Name of Medical Practitioner - please print	Medical License Number
Identify Medical Practice	Area Code - Office Telephone Number

I certify that I have examined this applicant, that the above answers are a result of the examination, and that I am licensed to practice in Wisconsin.

Signature of Reporting Medical Practitioner	Date
X	

Section C - Cooperative Driver Training Program (CDTP) or DMV Use

School Name	School ID #	Instructor Name	Instructor ID #
Knowledge Tests – 80% or higher to pass	Highway Signs ☐ Pass ☐ Fail	Driver Training Instructor Test ☐ Pass ☐ Fail	Class D ☐ Pass ☐ Fail

Section D - DMV Use Only

CDL	Skills Test (MV3543 or MV3544)	Oral (MV3222 or MV3717)
☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

Brake Reaction Results — Average of 3 times: At least 50/100 second using portable test ☐ Pass ☐ Fail **OR** During Skills Test - 1 time ☐ Pass ☐ Fail

Visual Acuity - Must be at a minimum of 20/40 in one eye and 70 degrees field of vision in one eye, otherwise, additional vision information will be required prior to approval.

	Without RX	**With RX**	**Temporal Field**	Normal Color Perception ☐ Yes ☐ No
Right Eye	20/	20/	$\geq 70^0$ ☐ Yes ☐ No	20% Minimum Depth Perception - Able to see sign closest to eye ☐ Yes ☐ No
Left Eye	20/	20/	$\geq 70^0$ ☐ Yes ☐ No	Hearing - Must be normal ☐ Corrected ☐ Uncorrected

Comments

Date	Place of Examination	Examiner Signature / ID #

Section E - DTS Coordinator Use Only — Driver Record Check — Background Check ☐ CIB ☐ JUS ☐ CCAP ☐ SOR ☐ NAR