

DRIVER INSTRUCTOR APPLICATION

MV3112 2/2009 s.343.62 Wis. Stats.

Return to: Wisconsin Department of Transportation
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
 Under 18 only
 Adults and under 18
 Commercial Motor Vehicle (CMV)

Telephone: 608-264-7495
E-mail: dotdrvtrnschool@dot.wi.gov

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

Reason for Duplicate

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
6. Mailing Address and/or Post Office Box - ONLY if Different from Residence		4. Birth Date	5. Sex
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.

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|--------------------------|--------------------------|---|
| 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. |
| <input type="checkbox"/> | <input type="checkbox"/> | |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 Have you been associated with a driver school when its license was revoked, suspended, cancelled or denied?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. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. In the past, have you been convicted of a felony? If yes, give reason, date and location. |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Are you required to register with the Sex Offender Registry? If yes, give reason, date and location. |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Are you required to register with the Nurse Aide Registry? If yes, give reason, date and location. |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you had any instructor license revoked, suspended, cancelled, or denied? If yes, give reason, date and location. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____. |
| | | <input type="checkbox"/> Brain or Head Injury <input type="checkbox"/> Heart <input type="checkbox"/> Mental <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Lung <input type="checkbox"/> Muscle or Nerve <input type="checkbox"/> 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 - Medical 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 90 days of this application.

Examination Date - Required

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

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 <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Driver Training Instructor Test <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Class D <input type="checkbox"/> Pass <input type="checkbox"/> Fail

Section D - DMV Use Only

CDL <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Skills Test (MV3543 or MV3544) <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Oral (MV3222 or MV3717) <input type="checkbox"/> Pass <input type="checkbox"/> Fail
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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 - 20/40 in one eye (either one) and at least 20/100 in other eye; Temporal Field of Vision of **at least 70°** in EACH eye

	Without RX	With RX	Temporal Field	Normal Color Perception <input type="checkbox"/> Yes <input type="checkbox"/> No
Right Eye	20/	20/	≥ 70° <input type="checkbox"/> Yes <input type="checkbox"/> No	20% Minimum Depth Perception - Able to see sign closest to eye <input type="checkbox"/> Yes <input type="checkbox"/> No
Left Eye	20/	20/	≥ 70° <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing - Must be normal <input type="checkbox"/> Corrected <input type="checkbox"/> Uncorrected

COMMENTS

Date	Place of Examination	Examiner Signature / ID #
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Section E - DTS Coordinator Use Only

Driver Record Check	Background Check <input type="checkbox"/> CIB <input type="checkbox"/> JUS <input type="checkbox"/> CCAP <input type="checkbox"/> SOR <input type="checkbox"/> NAR
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