# DRIVER TRAINING SCHOOL
# INSTRUCTOR PHYSICAL EXAMINATION

State Form 53312 (R6 / 9-24)
INDIANA BUREAU OF MOTOR VEHICLES

The legal authorization for this form is 140 IAC 4-1.3-1.

Indiana Bureau of Motor Vehicles
http://www.mybmv.com

*INSTRUCTIONS:*
1. *Complete in blue or black ink or print completed form.*
2. *Form must be completed in its entirety by a licensed physician.*
3. *Applicant must submit this form online.*

| PHYSICAL EXAMINATION | | |
|---|---|---|
| Name of Applicant *(last, first, middle initial)* | Date of Examination *(mm/dd/yyyy)* | |
| Does the applicant have a minimum corrected visual acuity of 20/40 in each eye? | ☐ Yes | ☐ No |
| Does the applicant have visual fields of at least 55 degrees in each eyes? | ☐ Yes | ☐ No |
| Does the applicant have any communicable diseases? | ☐ Yes | ☐ No |
| Does the applicant have any medical condition that may affect the applicant's ability to operate a vehicle safely, give demonstrations or supervise students operating motor vehicles? | ☐ Yes | ☐ No |
| Remarks: | | |
| | | |
| | | |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| Physician License Number/Nurse Practitioner Number | License State | |
| I certify that I have conducted a physical examination of the above named applicant. I swear or affirm that the information on this form is true and correct. I understand making a false statement may constitute the crime of perjury. | | |
| Signature of Physician/Nurse Practitioner | Printed Name | Date *(mm/dd/yyyy)* |

| APPLICANT RELEASE | |
|---|---|
| I authorize the information contained on this form and any attachments to be released to the Bureau of Motor Vehicles. | |
| Signature of Applicant | Date *(mm/dd/yyyy)* |