Reset Form

DRIVER TRAINING SCHOOL
INSTRUCTOR PHYSICAL EXAMINATION

State Form 53312 (R5 / 8-18)

INDIANA BUREAU OF MOTOR VEHICLES

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
Is the applicant mentally sound?	☐ 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	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	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)*