



**DRIVER TRAINING SCHOOL
INSTRUCTOR PHYSICAL EXAMINATION**

State Form 53312 (R4 / 1-15)
INDIANA BUREAU OF MOTOR VEHICLES

Indiana Bureau of Motor Vehicles
Attn: Driver Education
100 North Senate Avenue
Room N481
Indianapolis, IN 46204

INSTRUCTIONS:

1. Complete in blue or black ink or print completed form.
2. Form must be completed in its entirety.
3. Applicant must mail this form along with other required instructor application documents to the above address.

PHYSICAL EXAMINATION		
Name of Applicant (<i>last, first, middle initial</i>)		Date of Examination (<i>mm/dd/yyyy</i>)
Does the applicant have a minimum corrected visual acuity of 20/40 in each eye?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the applicant have visual fields of at least 55 degrees in each eyes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the applicant mentally sound?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the applicant have any communicable diseases?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 (<i>mm/dd/yyyy</i>)
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 (<i>mm/dd/yyyy</i>)	