

Driving Instructor Physical Form

Instructor/Applicant Name _____

Describe any history of Epilepsy, Heart Disease, or Fainting Spells

| | | |
|---|--|------------|
| Heart | Blood Pressure | Pulse Rate |
| Respiratory System | Reflexes | |
| Genito Urinary System | Urine | |
| Does Applicant have the normal use of both (answer "yes" or "no" Describe under remarks) Arms _____ Hands _____ Legs _____ Feet _____ Eyes _____ | | |
| Mental Alertness (observation) | | |
| Hearing Deaf _____ Poor _____ Fair _____ Good _____ | Hearing Results Both _____ Right _____ Left _____ | |
| Acuity Reading with Glasses Both 20/ _____ Right 20/ _____ | Acuity Reading without Glasses Left 20/ _____ Both 20/ _____ Right 20/ _____ Left 20/ _____ | |

Remarks

Physician please note: Applicant must sign in the presence of the examining physician.

Applicant's Signature

I certify that I have correctly recorded the results of the examination, and that to the best of my judgement the applicant is _____ is not _____ physically qualified to train an individual in the operation of a motor vehicle. (State any exceptions)

Signed _____ M.D.

Place of Examination

Physician's Address

| | | |
|---------------------|-----|------|
| Date of Examination | | |
| Mo. | Day | Year |

When you have completed this form, mail to the Office of the Secretary of State, Commercial Driver Training School Section, 650 Roppolo Lane, Elk Grove Village, Illinois 60007.