

Driver's License
300 SW 29th Street
PO Box 2188
Topeka KS 66601-2188
Mark A. Burghart, Secretary



Phone: 785-296-3671
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www.ksrevenue.gov
Laura Kelly, Governor

Physical Examination and Health Certificate for Driver Training School Instructor

Applicant Section

Name: _____ Date: _____
Address: _____ Phone#: _____
Email: _____ Date of Birth: _____ Age: _____
Gender: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

The person named above is applying for a driver training school instructor license and is required by law to submit a physical examination upon request. Please complete this form in full and return it to the applicant.

Health History

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any other nervous disorder
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Psychiatric Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Extensive confinement
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Seizures, fits, convulsions, fainting
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Suffering from any other disease
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Head or Spinal Injuries	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Muscular disease

If answer to any of the above is yes, please explain: _____

Yes <input type="checkbox"/>	No <input type="checkbox"/>	Vision abnormalities or eye disease (not correctable by corrective lenses)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Cardiovascular disease (e.g., stroke, angina, heart failure, hypertension)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Respiratory disease (e.g., emphysema, asthma)
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes mellitus and/or other endocrine disorders
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Impairment due to alcohol or drugs
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Blood pressure
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart and/or circulatory system disorder
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing abnormality
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Restricted use of any extremity
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Speech defect that would prevent giving clear directions or commands
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Physical, mental, emotional condition which would affect ability to instruct others
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Any communicable disease
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Presently on medication? State reason and possible side effects _____

Comments: _____

Would present medication affect the person's ability to instruct students? _____

I, the undersigned physician, found nothing during the examination of the applicant that would interfere with their duties as a driving instructor. I will approve them as physically fit to be a training instructor.

Signature: _____ Printed Name: _____ Date: _____

Please return this completed form to KDOR_DOVDE@KS.GOV.