



KANSAS STATE DEPARTMENT OF EDUCATION COMMERCIAL DRIVER TRAINING SCHOOL INSTRUCTOR PHYSICAL EXAMINATION AND HEALTH CERTIFICATE

Please return this completed form to Driver Education, rmeinholdt@ksde.org LSOB, 900 SW Jackson St, Suite 106, Topeka, KS 66612

Name _____

Address _____ Phone # () _____

Soc. Sec. No. _____ Date of Birth _____ Age _____

Table with 5 columns: Sex, Height, Weight, Hair, Eyes

To be Completed by Physician

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 No Asthma Yes No Any other nervous disorder
Yes No Psychiatric disorder Yes No Tuberculosis
Yes No Extensive confinement by illness or injury Yes No Seizures, fits, convulsions, fainting
Yes No Kidney Yes No Suffering from any other disease
Yes No Head or spinal injuries Yes No Muscular disease

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

- Yes No Vision abnormalities or eye disease (not correctable by eyeglasses)
Yes No Cardiovascular disease (e.g., stroke, angina, heart failure, hypertension)
Yes No Respiratory disease (e.g. emphysema, asthma)
Yes No Diabetes mellitus and/or other endocrine disorders
Yes No Impairment due to alcohol or drugs
Yes No Blood pressure
Yes No Heart and/or circulatory system disorder
Yes No Hearing abnormality
Yes No Restricted use of any extremity
Yes No Speech defect that would prevent giving clear directions or commands
Yes No Physical, mental, emotional condition which would affect ability to instruct others in the operation of a motor vehicle
Yes No Any communicable disease
Yes No Presently on medication-state reason and possible side effects _____

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

Comments: _____

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

X _____ PHYSICIAN'S SIGNATURE DATE PHYSICIAN'S NAME - PRINTED

STREET ADDRESS CITY STATE ZIP PHONE