DRIVER INSTRUCTOR APPLICATION

Wisconsin Department of Transportation (WisDOT)
MV3112 6/2015 s.343.62 Wis. Stats.

Clear Form | Print

WisDOT Driver Training School Program
PO Box 7920, Madison, WI 53707-7920
Telephone: (608) 264-7495

Section A – Customer *(please print)*

APPLICATION TYPE *(check one)*

- ☐ Original
- ☐ Renewal
- ☐ Duplicate (complete front only) Reason for duplicate:

LICENSE TYPE *(check all that apply)*

- ☐ Adult only
- ☐ Under 18 only
- ☐ Adults and under 18
- ☐ Commercial motor vehicle (CMV)

* The social security number may be used for purposes authorized by law.

Neatness and accuracy are important since your license will be prepared from the information supplied on this application.

1. Applicant Name (First - Middle Initial - Last)	2. Current Instructor ID Number	3. Instructor (Area Code) Telephone Number

4. Current Residence Address	City	ZIP Code	5. Birth Date
			M M – D D – Y Y Y Y

6. Mailing Address and/or Post Office Box - ONLY if Different from Residence

7. Social Security Number *	8. Driver License Number	9. Expiration Date	10. State of Issuance
1 2 3 – 4 5 – 6 7 8 9	1 2 3 4 – 5 6 7 8 – 9 10 11 12 – 13 14		

11. Are you a WisDOT employee? ☐ No ☐ Yes – Give Division and Bureau:

12. List all driving schools where you will instruct. For each driving school, include ID number, complete address, and telephone number. Attach a separate page if more space is needed.

YES	NO	
☐	☐	13. In the past 5 years, have you been licensed in another state or Canada? If yes, list location and submit a driving record from there.
☐	☐	14. Have you been associated with a driver school when its license was revoked, suspended, cancelled or denied? If yes, give school name, reason, date and location.
☐	☐	15. Are you employed by, or do you have financial interest in a third party tester for CMV? If yes, give third party tester name, address and telephone number.
☐	☐	16. In the past, have you been convicted of a felony? If yes, give reason, date and location.
☐	☐	17. Are you required to register with the Sex Offender Registry? If yes, give reason, date and location.
☐	☐	18. Are you required to register with the Nurse Aide Registry? If yes, give reason, date and location.
☐	☐	19. Have you had any instructor license revoked, suspended, cancelled, or denied? If yes, give reason, date and location.
☐	☐	20. In the past year, have you had a loss of consciousness or muscle control, caused by any of the following conditions? If yes, check condition(s) and give date:

☐ Traumatic Brain or Head Injury ☐ Heart ☐ Mental ☐ Seizure Disorder ☐ Diabetes ☐ Lung ☐ Muscle or Nerve ☐ Stroke

21. I have completed one of the following training programs. Attach copies. (If applying for renewal or duplicate, disregard this question.)

☐ 40 Hour Course ☐ DPI Certification ☐ 9 Credits in Driver Education

22. For renewal only: I have completed the required traffic safety workshop.

☐ Yes, give date: ☐ No

23. I certify that the answers and statements on this application are true and correct. I understand that I may be required to submit additional medical information if requested. I also understand that this application will be denied if I have unpaid taxes or child support. I authorize the examining physician to release my medical history upon request to the Wisconsin Department of Transportation.

X _____ _____

(Applicant Signature) (Date – m/d/yyyy)

(Over)

Section B – Health Care Practitioner *(please print)*

Please answer ALL of the following questions regarding the applicant identified on the other side of this form.

This report must be based on an examination conducted within the previous 24 months. Examination Date – **Required:** _____

YES	NO		YES	NO		YES	NO	
☐	☐	Alcohol or other drug abuse or dependency within the past 12 months	☐	☐	Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date:	☐	☐	Loss of, or altered consciousness Date:
☐	☐	Alcohol or other drug abuse or dependency within the past 12 – 24 months Controlled by treatment? ☐ Yes ☐ No	☐	☐	Kidney disease, dialysis	☐	☐	Seizures, epilepsy Episode Date:
☐	☐	Positive TB in a communicable form	☐	☐	Diabetes or elevated blood sugar controlled by ☐ Diet ☐ Pills ☐ Insulin	☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Heart disease or heart attack, stroke, other cardiovascular condition	☐	☐	Lung disease, emphysema, asthma, chronic bronchitis	☐	☐	Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
			☐	☐	Required oxygen use	☐	☐	Blood pressure over 180/105
						☐	☐	Missing or impaired hand, arm, foot, leg
						☐	☐	Mental/Emotional Functions

For any YES answers, indicate onset date, diagnosis, and any current limitations. List all medications (including over-the-counter medications) used regularly or recently. _____

YES	NO	
☐	☐	The individual who is requesting this physical is applying to become a licensed driver training school instructor. In a vehicle, he/she may be instructing, at the same time, 4 students that may be under the age of 18 [Wis. Stat. 343.07(1g)(a)(1)]. Do you believe this person is physically and mentally capable to act as a driver instructor?

Name of Medical Practitioner *(please print)*	Medical License Number
Identify Medical Practice	(Area Code) Office Telephone Number

I certify that I have examined this applicant, that the above answers are a result of the examination, and that I am licensed to practice in Wisconsin.

X _____

(Reporting Medical Practitioner – Signature) (Date – m/d/yyyy)

Section C – Cooperative Driver Training Program (CDTP) or DMV Use

School Name	School ID Number	Instructor Name	Instructor ID Number

Knowledge Tests – 80% or higher to pass	Highway Signs	Driver Training Instructor Test*	Class D*
	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

Section D – DMV Use Only

CDL	Skills Test (MV3543 or MV3544)	Oral (MV3222 or MV3717)	Brake Reaction Results Skills Test – 1 time*
☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

Visual Acuity – Must be at a minimum of 20/40 in one eye and 70 degrees field of vision in one eye, otherwise, additional vision information will be required prior to approval.

	Without RX	With RX	Temporal Field		
Right Eye	20/	20/	≥ 70°	☐ Yes ☐ No	Normal Color Perception ☐ Yes ☐ No
Left Eye	20/	20/	≥ 70°	☐ Yes ☐ No	Hearing – Must be normal ☐ Corrected ☐ Uncorrected

Comments

X _____

(Date – m/d/yyyy) (Place of Examination) (Examiner Signature / ID Number)

Section E – DTS Coordinator Use Only Driver Record Check Background Check ☐ CIB ☐ JUS ☐ CCAP ☐ SOR ☐ NAR

*Class D – Instructor Only