DRIVER INSTRUCTOR APPLICATION

Wisconsin Department of Transportation
MV3112 5/2018 s.343.62 Wis. Stats.

Clear Form Print

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

Section A – Customer *(please print)*

APPLICATION TYPE *(check one)* ☐ Original ☐ Renewal ☐ Duplicate

LICENSE TYPE ☐ Adult Only ☐ Under 18 Only ☐ Adults and Under 18 ☐ Commercial Motor Vehicle ☐ Online FYR Only

COURSES APPLYING FOR ☐ Classroom ☐ 6/6 Behind-the-Wheel ☐ 9 Hours BTW ☐ Adults Only ☐ Online
☐ Failure to Yield *(choose one of the following)*: ☐ Classroom ☐ Online ☐ Both
☐ Instructor Training *(choose one of the following)*: ☐ Public ☐ Private ☐ Both
☐ CMV

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 Have you been associated with a driver school when its license was revoked, suspended, cancelled or denied?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.
☐ No ☐ Yes, give date, location, and facilitator/organizer:

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)*

Based on an examination conducted within the previous 24 months, please answer ALL of the following questions regarding the applicant on this form.

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 who 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