IDAHO DRIVER'S TRAINING APPLICANT

PLEASE FILL OUT THIS FORM AND BRING IT WITH YOU

SCHOOL _____ HOME PHONE # _____

Who are you taking classes through? _____

Legal First Name (Print in Full) _____

Legal Middle Name (Print in Full) _____

Legal Last Name (Print in Full) _____

Street/Residence Address _____

City _____ State _____ Zip _____

Mailing Address if Different _____

Social Security # _____ Date of Birth _____

Sex: M _____ F _____ Height _____ f t _____ in _____ Weight _____

Hair Color _____ Eye Color _____ Glasses/Contacts (Y/N) _____

Are you now being or have been treated for any of the following health conditions within the past 12 months that may affect your ability to drive?

_____ Epilepsy or Seizures _____ Crippling Arthritis _____ Fainting Spells

_____ Paralysis _____ Parkinson's _____ Strokes

_____ Heart Trouble _____ Diabetes _____ Alzheimer's

_____ Multiple Sclerosis _____ Use of drugs, alcohol or prescribed medication

_____ Any other physical, mental or emotional problems not listed

NONE OF THE ABOVE MEDICAL CONDITIONS APPLY TO ME _____