



# Driver Training Instructor Application

Complete **ALL** requirements listed below and click each checkbox to indicate completion:

- ☐ **Step 1: Review [Driver Training Schools Rules & Regulations](#)**
- ☐ **Step 2: Register with [Georgia Applicant Processing System \(GAPS\)](#) for fingerprinting requirement**  
\*\*NOTE: Register only; application must be submitted to DDS before fingerprinting can be completed
- ☐ **Step 3: Send signed application to Regulatory Compliance, P.O. Box 80447, Conyers, GA 30013. Your complete application must include all of the following:**
  - ☐ Certified check or money order for **\$30.00 application and certification exam fee**  
\*\*NOTE: If you have a GaPSC teacher certificate for Safety & Driver Education, the fee is only \$5.00 (attach certificate)
  - ☐ Complete, notarized **DDS Consent for Background Investigation Form**
  - ☐ Notarized **Employment Letter – Must be:**
    - ☐ Signed by Driver Training School owner
    - ☐ Dated within 90 days of application
  - ☐ **DDS Physical Examination form – Must be:**
    - ☐ Completed by your physician
    - ☐ Dated within 30 days of application
  - ☐ Drug Screen **Lab Report – Must be:**
    - ☐ Completed by an accredited lab
    - ☐ Screened for the following:
      - ☐ Amphetamines
      - ☐ Cocaine
      - ☐ Marijuana/THC
      - ☐ Opiates
      - ☐ PCP
    - ☐ Dated within 30 days of application
  - ☐ Certified Out-of-State Motor Vehicle Report  
\*\*NOTE: Required if licensed in a state other than Georgia in the last 5 years
- ☐ **Step 4: WAIT for notification to complete the following:**
  - ☐ GAPS Fingerprinting
  - ☐ Driver Training Instructor Exam

## STATEMENT OF COMPLETION

- \* I hereby certify this application includes all documents and fees required for certification approval.
- \* I understand an incomplete application may result in my application being rejected and fees forfeited.
- \* I accept that the average time for application processing is 30 days provided all requirements are met.
- \* I acknowledge that I must be invited to register for the exam upon successful processing of my application and not prior.
- \* I understand that I am not authorized to go for fingerprinting until the completed application has been submitted to Regulatory Compliance and notification from Gemalto is received.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Legal Signature

\_\_\_\_\_  
Date



# Driver Training Instructor Application

## SECTION 1: School Information

1.1 List, in the space provided below, the driver training school where you will be employed.

Driver Training School Name

Driver Training School Street Address

City

Zip

## SECTION 2: Applicant Information

Last Name

First Name

MI

Suffix

Date of Birth

Driver's License #

State of Issuance

Current Home Address

City

State

County

Zip

Mailing Address ☐ Same as above

City

State

County

Zip

Home Phone Number

Cell Phone Number

Work Phone Number

**\*\*Each applicant must provide a secure, individual email address that only the applicant can access. The Department will use this email address for official purposes. The applicant should check the email account during the certification process.\*\***

**\*\* Email Address**

☐ **Check to confirm the Driver Training School listed above can be copied on emails sent to you about this application.**

## SECTION 3: Applicant Qualifications

3.1 Are you a United States citizen?

☐ Yes ☐ No **\*\*Note: Applicants that are not U.S. citizens must submit proof of lawful status with the application.**

3.2 Are you currently employed with the Georgia Department of Driver Services?

☐ Yes ☐ No

3.3 Do you have a spouse, dependent child, dependent stepchild, or dependent adopted child that is currently employed with the Georgia Department of Driver Services?

☐ Yes ☐ No

3.4 Are you currently under a contractual agreement to provide services or affiliated with an entity or agency that provides services to the Georgia Department of Driver Services?

☐ Yes ☐ No

3.4.1 If you answered "Yes" to question 3.4., please list the entity or agency:

3.5 Are you at least 21 years of age?

☐ Yes ☐ No



# Driver Training Instructor Application

## **SECTION 4: Applicant Affirmation**

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Under penalty of law, I do hereby swear or affirm that all the information that I have provided herein is complete and accurate.

I will refrain from abusing alcohol and illegal or other drugs.

I will maintain all reports and information as specified in the DDS rules and regulations.

I hereby authorize the release to DDS of any information necessary for the determination of my application for instructor certification. I understand that this information will be used only for the purpose of processing my application. Photocopies of this authorization will be valid for the purpose of obtaining requested information.

*I understand that to knowingly make a false statement or conceal a material fact in this application will result in the denial of my application, the cancellation of my certification (if applicable), and criminal charges being brought against me.*

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**Legal Signature**

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**Date**

**Georgia Department of Driver Services**  
**Regulatory Compliance Division, 2206 Eastview Parkway, Conyers, GA 30013**  
**CONSENT FOR BACKGROUND INVESTIGATION**

OFFICE USE ONLY FILE NUMBER:	OFFICE USE ONLY DATE APPLICATION RECEIVED:	OFFICE USE ONLY BACKGROUND DRIVING HISTORY <input type="checkbox"/> Pass <input type="checkbox"/> Fail CRIMINAL HISTORY <input type="checkbox"/> Pass <input type="checkbox"/> Fail	OFFICE USE ONLY
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APPLICANT TYPE: (OFFICE USE ONLY)

<input type="checkbox"/> DUI Risk Reduction	<input type="checkbox"/> Owner	<input type="checkbox"/> Director	<input type="checkbox"/> Instructor
<input type="checkbox"/> Driver Improvement	<input type="checkbox"/> Owner	<input type="checkbox"/> Instructor	<input type="checkbox"/>
<input type="checkbox"/> Driver Training	<input type="checkbox"/> Owner	<input type="checkbox"/> Instructor	<input type="checkbox"/>
<input type="checkbox"/> Non-Commercial Third Party	<input type="checkbox"/> Tester	<input type="checkbox"/> Examiner	<input type="checkbox"/>
<input type="checkbox"/> CDL Third Party	<input type="checkbox"/> Tester	<input type="checkbox"/> Examiner	<input type="checkbox"/>
<input type="checkbox"/> Ignition Interlock	<input type="checkbox"/> Owner/Operator	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Commercial Veh. Training School	<input type="checkbox"/> Owner	<input type="checkbox"/> Director	<input type="checkbox"/> Instructor
<input type="checkbox"/> Motorcycle Safety	<input type="checkbox"/> Rider Coach	<input type="checkbox"/> Rider Coach Trainer	<input type="checkbox"/> Private Site Manager
<input type="checkbox"/> For-hire License Endorsement			

Last Name	First Name	Middle	Phone Number
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Driver's License Number (Include ALL zeros)	DL Issue date (Exam date)	State	Social Security Number	Date of Birth (MM/DD/YYYY) / /
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Current Street Address	City and State	Zip Code
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Have you held any driver's license from another state in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, list state(s) and license number(s)
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Program/School Name (if applicable)	Phone Number
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Address	City and State	Zip Code
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Have you been convicted of, plead guilty to, or plead nolo contendere to any crime, whether felony or misdemeanor, in this state, in any other state, or in the federal system within the past ten (10) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you served time for any crime, whether felony or misdemeanor, in this state, in any other state, or in the federal system within the past ten (10) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been on probation or parole for any crime, whether felony or misdemeanor, in this state, in any other state, or in the federal system within the past ten (10) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a charge(s) or a court hearing pending, or are you under indictment or accusation for any crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the above, please note the offense, date and location below:

<u>Offense</u>	<u>Date</u>	<u>City/State</u>

I hereby apply for Certification(s) to be issued by the Regulatory Compliance Division of the Department of Driver Services (DDS). I understand that my national and state criminal history, driver's history, and legal presence will be checked. I hereby give consent for the DDS to conduct whatever investigations necessary to determine my eligibility to hold such a certificate. I understand that false, misleading, or incomplete information in my application or on this Consent Form may result in certificate denial, cancellation, suspension, or revocation, as well as possible criminal prosecution and civil action. Under penalty of perjury, I do hereby swear or affirm that the information contained within this application, and any statements made in connection therewith, are complete, true and correct.

Applicant Signature	Date
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**THIS CONSENT FORM MUST BE NOTARIZED**

Subscribed to and sworn before me:

Seal or Stamp

Notary Signature
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Date
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My Commission Expires: \_\_\_\_\_

## **Georgia Applicant Processing System (GAPS)**

The **Georgia Applicant Processing System (GAPS)** fingerprinting process must be completed by all regulated program applicants to satisfy the statutorily required national and state criminal history check. Fingerprint results obtained from any source other than the approved GAPS process will not be accepted.

**When submitting a certification application to Georgia Department of Driver Services (DDS), please follow the fingerprinting instructions outlined below.**

### **Step 1: Register for fingerprinting.**

- Go to the following website: <https://www.aps.gemalto.com/ga/index.htm>
- From the GAPS Georgia Home page, click "Applicant Registration."
- Click "Department of Driver Services (DDS)."
- On the GAPS DDS page, click "Register to be Fingerprinted."
- Click the checkbox to accept the Privacy Rights terms and click "Continue."
- Select the **Reason for Fingerprinting** based on the type of application being submitted. (NOTE: CDL and MSP applicants should select DT Instructors or DT Owner).
- Leave the **Requesting Agency ID** and **Position Applied for** fields blank, and do not change **Payment Type** from "Credit Card."
- Complete all areas under **Personal Information**, **Home Address**, and **Mailing Address** and click "Continue."
- Review your information and click "Submit."
- Follow system prompts to submit the credit card payment and print your receipt.

### **Step 2: Submit application to DDS and WAIT for notification from Gemalto.**

- When your application is received by DDS Regulatory Compliance, DDS will approve your GAPS registration on the Gemalto website.
- After the registration approval, Gemalto will notify you by email that you can be fingerprinted.

### **Step 3: Go to a GAPS location to be fingerprinted.**

- To find a location, return to the Gemalto GAPS [website](https://www.aps.gemalto.com).
- Click "Fingerprint Locations."
- Click on a county in the map for a list of GAPS locations in that area.
- Report to the selected location for fingerprinting and take your receipt.

GAPS results, in most cases, are usually accessible to DDS within 48 hours of fingerprinting and will remain available for 30 days. Additional information regarding this process, policies, fees, and locations may be found on the Gemalto GAPS website at <https://www.aps.gemalto.com>.



# DRIVER TRAINING INSTRUCTOR PHYSICAL EXAMINATION FORM

This form must be completed by the licensed physician that has examined you within (30) days of filing application. *The Driver Training Instructor Applicant should complete Health History and Instructor's Statement. The Examining Doctor should complete Physical Information, Laboratory Findings, and Doctor's Statement.*

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

## Health History

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Any illness or injury in last 5 years	<input type="checkbox"/>	<input type="checkbox"/>	Eye disorders or impaired vision (except corrective lenses); Eye injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Head/Brain injuries, disorders or illnesses	<input type="checkbox"/>	<input type="checkbox"/>	Ear disorders, loss of hearing or balance
<input type="checkbox"/>	<input type="checkbox"/>	Seizures, epilepsy Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or heart attack; other cardiovascular condition Medication _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure Medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery (valve replacement/bypass, angioplasty, pacemaker)
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Stroke or paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease, emphysema, asthma, chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Spinal injury or disease
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease, dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Regular, frequent alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin	<input type="checkbox"/>	<input type="checkbox"/>	Nervous or psychiatric disorders e.g., severe depression Medication _____

Other illness or injuries: \_\_\_\_\_

## Physical Information

### General appearance and development:

☐ Good

☐ Fair

☐ Poor

Height: _____	Weight: _____
Eyes for Distance (without glasses/contacts):	Right 20 / _____ Left 20 / _____
Eyes for Distance (with glasses/contacts):	Right 20 / _____ Left 20 / _____
Color Vision: _____	Horizontal Field of Vision: Right: _____ Left: _____
Ears (Hearing @ 20 ft.):	Right: _____ Left: _____

<u>Yes</u>	<u>No</u>	<u>Body System:</u>	<u>Check For:</u>
<input type="checkbox"/>	<input type="checkbox"/>	General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.
<input type="checkbox"/>	<input type="checkbox"/>	Eyes	Papillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration.
<input type="checkbox"/>	<input type="checkbox"/>	Ears	Middle ear disease, occlusion of external canal, perforated eardrums.
<input type="checkbox"/>	<input type="checkbox"/>	Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Heart	Murmurs, extra sounds, enlarged heart, pacemaker, ICD.
<input type="checkbox"/>	<input type="checkbox"/>	Lungs and chest, not breast examination	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal finding on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruit, hernia, significant abdominal wall muscle weakness.
<input type="checkbox"/>	<input type="checkbox"/>	Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.
<input type="checkbox"/>	<input type="checkbox"/>	Genito-urinary system	Hernias.
<input type="checkbox"/>	<input type="checkbox"/>	Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.
<input type="checkbox"/>	<input type="checkbox"/>	Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.
<input type="checkbox"/>	<input type="checkbox"/>	Extremities – Limb Impaired	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.

Comments: \_\_\_\_\_

### Laboratory Findings:

Urine: Spec. Gr.: \_\_\_\_\_ Protein: \_\_\_\_\_ Sugar: \_\_\_\_\_

Blood Pressure (Sitting): Systolic: \_\_\_\_\_ Diastolic: \_\_\_\_\_

Pulse: Before Exercise: \_\_\_\_\_ After Exercise: \_\_\_\_\_

**Instructor's Statement:** I affirm that all medical questions were answered honestly and to the best of my knowledge.

\_\_\_\_\_  
Signature of Driver Training Instructor Applicant

\_\_\_\_\_  
Date

### Doctor's Statement:

**I affirm that I have examined \_\_\_\_\_ on \_\_\_\_\_ (exam date)**  
**and found his/her physical condition sufficiently sound to perform the duties required of a Driver Training Instructor.**

\_\_\_\_\_  
Printed Name of Examining Doctor

\_\_\_\_\_  
Street Address of Examining Doctor

\_\_\_\_\_  
Signature of Examining Doctor

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Examining Doctor's Telephone No.: \_\_\_\_\_