**Issuance of a Learner’s Permit (CP)**
**Visually Impaired/Legally Blind Parent/Legal Guardian/Responsible Adult**

**INSTRUCTIONS:**
Thank you for your interest in applying for a Visually Impaired/Legally Blind Parent/Legal Guardian/Responsible Adult learner’s permit. The Georgia Department of Driver Services (DDS) offers a learner’s permit to 14-year-old minors whose Parent/Legal Guardian/Responsible Adult is visually impaired/legally blind.

The following general requirements and conditions apply:
- Minor must be at least 14 years old at the time of application
- Minor’s Parent/Legal Guardian/Responsible Adult must be visually impaired/legally blind
- Minor must complete the Visually Impaired/Legally Blind Parent packet
  - Minor’s Parent/Legal Guardian/Responsible Adult must have an Optometrist/Ophthalmologist complete the Vision Report (DDS-274B)

Once the above general requirements have been met, mail or fax the completed Vision Report (DDS-274B) to the following address for processing:

**Georgia Department of Driver Services**
**Medical Review Unit**
**P.O. Box 80447**
**Conyers, GA 30013**
**Fax: 770-344-3629**

Once an approval letter is received, the minor must visit a Customer Service Center (CSC) and bring the following documents to take the Vision and Knowledge Exams:
- $10.00 Non-Refundable Testing Fee
- Original/Certified Birth Certificate and/or Valid Passport
- Current Certificate of School Enrollment
- Social Security Card
- Parent/Legal Guardian/Responsible Adult must accompany you to sign the application
- Immigration documents required for non-citizens
- Completed Visually Impaired Parent Packet
  - Form for License/Permit/ID
  - Responsible Adult Affidavit

Please direct any questions to our Customer Contact Center at: (678) 413-8400.

Revised 07/2017
INSTRUCTIONS

IMPORTANT: Submit completed form to the Department of Driver Services (DDS) Medical Review Unit

1. Section A must be completed by the minor
2. Sections B and C must be completed by an optometrist/ophthalmologist currently licensed to practice in the United States of America

SECTION A – MINOR INFORMATION

Driver’s License or Identification Number (Optional): ________________________________ Date of Birth: _____ / _____ / ________

Full Legal Name:

Last Name: ___________________________ First Name: ___________________________ Middle Initial: ___________________________

Residential Address:

Street: __________________________________ City: ___________________________ State: _____________ Zip: _____________

City: ___________________________ State: _____________ Zip: _____________ Telephone #: ___________________________

SECTION B – VISUALLY IMPAIRED/LEGALLY BLIND PARENT/LEGAL GUARDIAN/RESPONSIBLE ADULT INFORMATION

Full Legal Name:

Last Name: ___________________________ First Name: ___________________________ Middle Initial: ___________________________

Date of Birth: _____ / _____ / ________ Relationship to Minor: ___________________________ Telephone #: ___________________________

Residential Address:

Street: __________________________________ City: ___________________________ State: _____________ Zip: _____________

City: ___________________________ State: _____________ Zip: _____________


2. Horizontal Field of Vision: Right _____ degrees Left _____ degrees Total _____ degrees

3. Were corrective lenses used for these results? ☐ Yes ☐ No

IMPORTANT: For proper identification, please have the person, whom you have examined, sign the report in your presence.

PARENT/LEGAL GUARDIAN/RESPONSIBLE ADULT SIGN HERE:

__________ _______________________________ Date of Examination

SECTION C – OPTOMETRIST/OPHTHALMOLOGIST CERTIFICATION

I, ___________________________, being licensed to practice in the United States of America, hereby certify that I have personally examined the vision of the above-named individual. The results indicated on this form represent a true record of my examination and that he or she signed this form in my presence.

Name of Practice: ____________________________________________________________

Optometrist/Ophthalmologist Name: ___________________________ ___________________________ ___________________________

Last Name: ___________________________ First Name: ___________________________ Middle Initial: ___________________________

Optometrist/Ophthalmologist License #: ___________________________

Practice Address: ___________________________ ___________________________ ___________________________

Street: __________________________________ City: ___________________________ State: _____________ Zip: _____________

Telephone #: ___________________________

☐ I certify that the parent/legal guardian/responsible adult of the minor, listed above, is visually impaired/legally blind.

X ___________________________ ___________________________ Date of Examination

Signature of Optometrist/Ophthalmologist

DD/MM/YYYY

Note: Vision Report cannot be more than 12 months old at time of request

** This form is subject to the provision of §O.C.G.A. 16-10-20 as it relate to providing false information to a government entity.
**SECTION A: FORM INFORMATION**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you now have or have you ever had a Georgia Driver’s License, Identification Card or Permit?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GEORGIA DRIVER’S LICENSE/ID/PERMIT#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIAL SECURITY #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEGAL FIRST NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MIDDLE OR MAIDEN NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEGAL LAST NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUFFIX: □ Jr. □ Sr. □ II □ III □ IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MAILING ADDRESS (STREET ADDRESS OR PO BOX, APT #, CITY, STATE, ZIP CODE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESIDENTIAL ADDRESS - If different from MAILING ADDRESS above (STREET ADDRESS, APT #, CITY, STATE, ZIP CODE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHONE #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alt. Phone #:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMAIL:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIRTH DATE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENDER: □ M □ F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEIGHT: Feet __ Inches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WEIGHT:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EYE COLOR:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION B: LEGAL STATUS**

By completing this form and signing the back, I swear that one of the following is true and accurate pursuant to O.C.G.A §50-36-1.

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ I am a United States citizen, OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ I am a legal permanent resident, OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act and lawfully present in the United States. Alien Registration number OR I-94 number for non-citizens:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SECTION C: ANSWER EACH QUESTION**

1. What can we help you with today? □ License/Permit □ Identification Card □ Reinstatement
2. Have you ever had a GA, Out-of-State or Foreign Driver’s License, Identification Card or Permit? □Yes □No
   - If Yes, please list (a)State or Country, (b)Name on Card, (c)Card Number and (d)Expiration Date:
     1. (a) __________________ (b) __________________ (c) __________________ (d) __/__/____
     2. (a) __________________ (b) __________________ (c) __________________ (d) __/__/____
3. Is your Driver’s License, Permit or privilege to drive currently revoked, suspended, cancelled or denied? □Yes □No
   - If Yes, list most recent: State ______________ Action __________________ Date of Action: __/__/____
4. Did you bring your GA, Out-of-State or Foreign Driver’s License, Identification Card or Permit with you today? □Yes □No
   - If No, why?: □ A Law Enforcement/Official has it; □ It is damaged, lost or stolen; □ New Customer
5. Do you wear prescription glasses or contact lenses for driving? □Yes □No
6. Have you ever suffered with: Seizures, Fainting or Other Loss of Consciousness? □Yes □No
   - If Yes, please list Date of Last Episode: __/__/____
7. Were you born on the same date (month/day/year) as any of your brothers and/or sisters AND/OR do you have any identical siblings? □Yes □No
   - If Yes, please list their full name(s):
8. Would you like to have “Organ Donor” displayed on your license or ID? □Yes □No
9. Would you like to donate $1 to the Georgia Drive for Sight Program for the prevention of blindness? □Yes □No
10. Would you like to donate to the Georgia Student Finance Authority for educational aid to children whose parents are/were public safety employees and were disabled or killed in the line of duty? □ $1 □ $5 □ $10 □Yes □No
11. Are you a male U.S. citizen or immigrant under age 26? □Yes □No

The Georgia Department of Driver Services (DDS) is required to ask all male U.S. citizens and immigrants, 18 - 25 years old, if they are registered with the U.S. Selective Service System (SSS). This DDS will report all responses to the SSS. You may be contacted by that agency as a result of your response. If you are not registered with the SSS, your signature constitutes consent to be registered. Please contact the SSS to verify registration. O.C.G.A §46-5.8.
SECTION D: VOTER REGISTRATION

The office where the registration application was submitted and any failure to register will remain confidential and will be used for voter registration purposes, unless you opt-out.

1. NOTE: All information provided on this form will be used for voter registration purposes, unless you opt-out. □ Opt-Out

2. RACE: □ American Indian □ Asian/Pacific Islander □ Black □ Hispanic/Latino □ Multiracial □ White □ Other □ Refuse

Your signature in this section serves as an attestation under penalty of perjury that all of the following requirements have been met:

- I am a citizen of the United States.
- I am at least 18 years of age.
- I reside at the address listed on this form.
- I am eligible to vote in Georgia.
- I am not serving a sentence for conviction of a felony involving moral turpitude. (You are serving a sentence if you are on probation or parole from your conviction of a felony involving moral turpitude.)
- I have not been judicially declared mentally incompetent, or if such declaration has been made, the disability has been removed.

WARNING: Any person who registers to vote knowing that such person does not possess the qualifications required by law, who registers under any name other than such person’s own legal name or who knowingly gives false information in registering, shall be guilty of a felony. The penalties for false registration are up to ten years in prison and up to a $100,000.00 fine pursuant to O.C.G.A. § 21-2-661.

DO NOT SIGN UNTIL INSTRUCTED BY A DDS TEAM MEMBER.

Customer’s Signature X ____________________________ Date mm / dd / yyyy

SECTION E: OTHER (Optional Information)

1. EMERGENCY CONTACT
   Name: ____________________________ Phone Number: ____________________________

2. Do you want your blood type displayed on your card? □ Yes □ No
   If Yes, please check blood type: □ A+ □ A- □ B+ □ B- □ AB+ □ AB- □ O+ □ O-

   NOTE: This information is voluntary and may be used to assist medical personnel. You agree to hold DDS harmless for any injuries that may occur from using this information.

SECTION F: REQUIRED SIGNATURE

This form can be notarized at the Customer Service Center for free.

DO NOT SIGN UNTIL INSTRUCTED BY A DDS TEAM MEMBER.

Customer’s Signature X ____________________________ Date mm / dd / yyyy

Examiner’s Signature ____________________________ Date mm / dd / yyyy

SECTION G: ADDITIONAL SIGNATURE REQUIRED FOR CUSTOMER UNDER 18 YEARS OF AGE

I _______ , hereby certify that I am the parent, guardian, or responsible adult approving the issuance of this driver’s license or instructional permit. I further certify that I have reviewed the information contained in this form, and that the information provided here is true and correct.

DO NOT SIGN UNTIL INSTRUCTED BY A DDS TEAM MEMBER.

Parent, Guardian, or Responsible Adult Signature X ____________________________ Date mm / dd / yyyy

Birth Date mm / dd / yyyy

Driver’s License/Identification/Social Security # ____________________________
Responsible Adult Affidavit

Applicant’s Information

Name: ___________________________ ___________________________ ___________________________ ___________________________

GA Driver License, Permit or Identification Card #: ___________________________ Date of Birth: __/__/____

Responsible Adult Information

Name: ___________________________ ___________________________ ___________________________ ___________________________

GA Driver License, Permit or Identification Card # or Other: ___________________________ Date of Birth: __/__/____

I am eighteen (18) years of age or older AND competent to verify the form AND have personal knowledge of the applicant.

Please initial one that applies

____ I am a parent or legal guardian.

____ I am a social worker who has worked with or assisted the applicant. (Must provide proof of Employee ID or Letter from State Agency).

____ I am an employee of a homeless shelter where the applicant resides. (Must provide proof of Employee ID or Letter from State Agency).

____ I am a step-parent of the applicant, as verified by a valid marriage license or certificate, or other such document demonstrating that the step-parent is married to a parent of the applicant.

____ Other persons whose identity can be verified by a state agency or official, school official or certified school records, or documentation from a federal agency or entity. Must provide documentation to show relationship. The following are examples of documents we can accept:

* Letter from Agency
* School Enrollment Form or Correspondence from School
* Tax Return
* Exchange Student Documents
* Military Enrollment Documents

Signatures

Applicant’s Signature: ___________________________ Date: ___________________________

Responsible Adult Signature: ___________________________ Date: ___________________________

Notary

Sworn to and subscribed before me, this __________ day of ___________________________, 20____

Day Month Year

Notary Signature

Notary Seal Here

Notice: This form is subject to the provisions of O.C.G.A. §16-10-20 as it relates to providing false information to a government entity.

DDS-357 (04/17)