



Instructor/Examiner/Director Recertification Application

Step 1 - ALL applicants:

- Sign the Statement of Completion at the bottom of this page and include this page with the application.
- Complete all sections of the application.
- Submit a notarized Consent for Background Investigation Form. (Form # RC-900)
- If you have been licensed in a state (or states) other than Georgia in the past five (5) years, you must obtain and submit a Motor Vehicle Report (MVR) from each state in which you were licensed except Georgia.
- All applicants must undergo a national and state fingerprint-based criminal background check using the Georgia Applicant Processing System (GAPS). Refer to the attached fingerprint instructions (RC-GAPS-999) for more information. *If you have been fingerprinted for any other Regulatory Compliance Division certification within the past six months, please provide the date of fingerprinting: _____*

Step 2 - Submit additional documents below, depending upon type of certification held:

DUI Alcohol or Drug Use Risk Reduction Program Director Recertification

- Submit documentation of 16 contact hours of approved continuing education.

DUI Alcohol or Drug Use Risk Reduction Program Instructor Recertification

- Submit documentation of 32 contact hours of approved continuing education.
- Submit documentation, such as class rosters or a letter from program owner/director, showing at least four (4) classes have been taught within the current certification period.

Driver Training Instructor Recertification

- Submit a recertification application fee of \$5.00 in the form of a money order, certified check, or cashier's check made payable to the Georgia Department of Driver Services.
- Submit a lab report from an **accredited lab** showing the results for drug screen taken within 30 days of filing the application. The lab report for the drug screening must include the results for the following substances: amphetamines, cocaine metabolites, marijuana metabolites, opiates, and phencyclidine.
- Submit the Physical Examination Form completed and signed by your doctor within 30 days of filing application. (Form # RC-DT-201)
- Submit a notarized letter (on school/company letterhead), signed and dated, from the owner of the driver training school that the applicant is or will be employed by the school.

Third Party Examiner Recertification

- Submit a signed Third Party Tester and Examiner Agreement. (Form # RC-TPT-300)

Driver Improvement Instructor Recertification

- Submit a recertification application fee of \$50.00 in the form of a money order, certified check, or cashier's check made payable to the Georgia Department of Driver Services.
- Submit a current instructor certificate(s) from an approved curricula provider. (AAA, ASC, DEOG, GARDE, NSC)

STATEMENT OF COMPLETION

I hereby certify that this application includes all documents and fees which are required to be attached for the approval as outlined above. I understand that the *average* time it may take to process this application is 30 days. I understand that an incomplete application or application lacking the necessary paperwork will result in my application not being processed and may result in fees being forfeited.

Printed Name

Legal Signature

Date

Please submit application, fees and all supporting documents to:
 Georgia Department of Driver Services
 Attn: Regulatory Compliance Division
 2206 Eastview Parkway
 Conyers, GA 30013

An application drop box is also available at the entrance of the Conyers Customer Service Center.



SECTION 1: *Applicant Information*

RRP Instructor RRP Director Driver Improvement Instructor Driver Training Instructor TPT Examiner
Cert. # _____ Cert. # _____ Cert. # _____ Cert. # _____ Cert. # _____
Exp. Date _____ Exp. Date _____ Exp. Date _____ Exp. Date _____ Exp. Date _____

Last Name		First Name		Middle Name	Suffix
Date of Birth		Driver's License #		State of Issuance	
Home Address		City	County	State	Zip Code
Mailing Address	<input type="checkbox"/> Same as above	City	County	State	Zip Code
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**

- 1.1** Are you currently employed with the Georgia Department of Driver Services, Georgia Department of Public Safety, or Georgia Department of Behavioral Health and Developmental Disabilities?
 Yes No
- 1.2** Are you or your spouse currently employed as a judge, public or private probation officer, public or private probation employee or agent, bail bondsman, employee or agent of a bonding company, law enforcement or peace officer, or employee of a court in this or any other state?
 Yes No
- 1.3** Do you own, manage, or operate a private company that has contracted to provide probation services for misdemeanor cases in this or any other state?
 Yes No
- 1.4** Do you have a spouse, dependent child, dependent stepchild, or dependent adopted child that is currently employed with the Georgia Department of Driver Services, Georgia Department of Public Safety, or Georgia Department of Behavioral Health and Developmental Disabilities?
 Yes No
- 1.5** Are you currently under a contractual agreement to provide services or affiliated with an entity that provides services to the Georgia Department of Driver Services, Georgia Department of Public Safety, or Georgia Department of Behavioral Health and Developmental Disabilities?
 Yes No
- 1.6** If you answered "Yes" to any of the questions above, give specific information detailing the company, agency, and job title.

- 1.7** Are you a United States citizen?
 Yes No

Note: Applicants that are not citizens of the United States must submit proof of lawful status with the application.



1.8 For RRP Directors ONLY: What program(s) are you directing?

<u>PROGRAM NAME</u>	<u>CERTIFICATION #</u>	<u>LOCATION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1.9 For Driver Training Instructors ONLY: What school(s) are you employed by?

<u>SCHOOL NAME</u>	<u>CERTIFICATION #</u>	<u>LOCATION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 2: Applicant Affirmation

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

Furthermore, I will maintain the confidentiality of all program records including, but not limited to assessment results and other program components. Records shall be confidential and shall not be released without the written consent of the student, except that such records shall be made available to DDS upon request.

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

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

I understand that DDS will list my name and address as public record.

I hereby authorize the release to DDS of any information necessary for the determination of my application for recertification. 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.

Legal Signature **Date**

Sworn to and subscribed before me

this ___ day of _____ 20__.

(SEAL)

Notary

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

OFFICE USE ONLY FILE NUMBER:	OFFICE USE ONLY DATE APPLICATION RECEIVED:	OFFICE USE ONLY BACKGROUND <input type="checkbox"/> DRIVER'S HIST P F <input type="checkbox"/> CRIMINAL HIST P F	OFFICE USE ONLY
OFFICE USE ONLY			

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"/> Driver Training	<input type="checkbox"/> Owner	<input type="checkbox"/> Instructor	
<input type="checkbox"/> Third Party	<input type="checkbox"/> Tester	<input type="checkbox"/> Examiner	
<input type="checkbox"/> Ignition Interlock	<input type="checkbox"/> Owner/Operator		
<input type="checkbox"/> For-hire License Endorsement			
<input type="checkbox"/> Commercial Veh. Training School	<input type="checkbox"/> Owner	<input type="checkbox"/> Instructor	
<input type="checkbox"/> Motorcycle Safety	<input type="checkbox"/> Coach		

Last Name	First Name	Middle	Date of Birth (MM/DD/YYYY) / /
Driver's License Number (Include ALL zeros)	Issue date (Exam date)	State	Social Security Number
Current Street Address		City and State	Zip Code
Have you held any other driver's license(s) in the past 5 years? Yes No	If so, list state(s) and license number(s)		Phone Number
Company			Phone Number
Address		City and State	Zip Code

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? Yes No

Have you ever 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? Yes No

Have you ever 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? Yes No

Do you have a charge(s) or a court hearing pending, or are you under indictment or accusation for any crime? Yes No

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

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.

Signature	Date
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THIS CONSENT FORM MUST BE NOTARIZED

Subscribed to and sworn before me:	SEAL OR STAMP
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Notary Signature	Date
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My commission expires: _____



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: _____

Yes	No	Body System:	Check For:
<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.: _____