Procedure for MossRehab Driving School Clients to Obtain Delaware Learner's Permit for Students

1) Student should sign "Special Driver Education Learner's Permit Request Form" and submit this form to high school driver education teacher and administrator for their signatures. The form should then be returned to the student.

2) Student should complete top portion of Delaware DMV medical form MV-346, and forward it to student's physician. The completed form should then be returned to the student.

3) Both of the above completed forms should be presented in person to one of the Delaware State testing centers (see attachment for specific addresses).

4) If student is under 18, he/she must be accompanied by parent or guardian. Student must be at least 16 years old.

5) The student must bring all of the following items to a State testing center in order for the State of Delaware to issue a permit:

   a) Completed "Special Driver Education Learner's Permit Request Form" signed by student, driver education teacher, and administrator (Item 1, above).

   b) Completed Delaware Division of Motor Vehicles form MV-346, signed by student and student's physician (Item 2, above).

   c) Certified birth certificate.

   d) Social Security card.

   e) Two proofs of Delaware residency.

   f) Permit fee of $40.

   g) Parent or guardian, if under 18 years of age.

6) Student should notify MossRehab Driving School when all of the above is completed so that MossRehab can request the permit from Delaware DMV.

REV 11/1/13

MossRehab
EINSTEIN HEALTHCARE NETWORK
Driving School For People with Disabilities
201 Old York Road – Suite 203 Jenkintown, Pa 19046
Phone: 215-886-7706 Fax: 215-886-7709

Prospective Patient: This clearance form is required for any evaluation or driving lesson. This form must be completed and submitted to the driving school in advance of scheduling an appointment. Please complete this top section of the form, and send to your physician for completion of the remainder.

Patient's Name _____ Phone _____

Contact for Appt (If other than patient): _____
(Name & Phone Number)

Patient's Full Address _____
Zip code

Referring Physician's Name _____

Physician's Address _____

Physician's Phone ( ) Physician's Fax ( )

Physician: In order to assist us in performing a driver's evaluation on the above-named individual, please complete the medical information requested below. Please return this form to MossRehab (address listed above) or fax it to 215-886-7709. You will receive a copy of the results of this evaluation.

Diagnosis: _____ ICD-9 _____ Date Of Onset _____

Date of birth _____ Date of last seizure (if any) _____

Is patient on medication which may interfere with ability to drive?

☐ Yes _____ ☐ No
(Indicate Medication & possible side effects)

Are you aware of any other medical and/or visual conditions which may affect this person's ability to drive?

☐ Yes _____ ☐ No
(Indicate Conditions & possible side effects)

Is this person ready to participate in a driver's evaluation?

☐ Yes ☐ No _____
(If no, indicate a later date)

Physician's Signature _____

License Number _____ NPI Number _____
(Required) (Required)

Driving School Locations: Jenkintown, Doylestown, Marlton (NJ), Rehoboth Beach (DE) Wilmington (DE), and Woodbury (NJ)

STATE OF DELAWARE DEPARTMENT OF TRANSPORTATION
DIVISION OF MOTOR VEHICLES
DRIVER IMPROVEMENT UNIT - MEDICAL RECORDS SECTION
PO BOX 698 - DOVER, DE 19903-0698

MEDICAL REPORT OF PHYSICIAN'S FINDINGS

Name: _____ DOB ___/___/___ License Number: _____

Address: _____

I hereby authorize Doctor _____ to perform any medical examination necessary for the purpose of determining my fitness to operate a motor vehicle. Also I understand that this authorization includes permission for the Director of Motor Vehicles and/or their designee to have this information reviewed by a Medical Board of unidentified physicians for the purpose of giving him/her a medical opinion on my case for a guidance in determining my medical capabilities to operate a motor vehicle safely. The information contained in this report is confidential and will be used solely for the purpose of drivers license considerations.

_____ _____
Date Signature of Applicant *(Required)*

(Legibility is a must)

Mental level for reading (check one) ☐ Inadequate ☐ Marginal ☐ Adequate Height: _____ Weight _____

(A) **ORTHOPEDIC AND NEUROMUSCULAR**: *(Please check as appropriate)*

Spastic, Amputations or Ankylosed Joints ☐ YES ☐ NO Joint Ataxia, Paralysis, or Weakness ☐ YES ☐ NO

Prosthetic Devices used for Driving ☐ YES ☐ NO Other Deformities or Abnormalities ☐ YES ☐ NO
If **YES** to any of the above, please describe: _____
_____
_____

(B) **CARDIO-VASCULAR**: *(Please check as appropriate)*

Strokes - Adams Syndrome ☐ YES ☐ NO Syncope ☐ YES ☐ NO Vertigos ☐ YES ☐ NO
Angina Pectoris ☐ YES ☐ NO Arteriosclerosis ☐ YES ☐ NO Arrhythmia ☐ YES ☐ NO
Cardiac Decompensation ☐ YES ☐ NO Dyspnea ☐ YES ☐ NO Blood Pressure _____
If **YES** to any of the above, please describe: _____
_____
_____

(C) **DIABETES**: *(Please check as appropriate)*

Is he/she a known diabetic? ☐ YES ☐ NO Status of Control _____
Duration: _____ Diabetic Acidosis ☐ YES ☐ NO _____

If **YES** to any of the above, please describe: _____
_____
_____

(D) **HEARING**: Normal? ☐ YES ☐ NO If **NO**, please describe: _____
_____

(E) **DRUGS AND/OR ALCOHOL**: *(Please check as appropriate)*

Any objective evidence or personal knowledge of addiction, habituation, or alcoholism? ☐ YES ☐ NO
If **YES**, please explain: _____
_____

 Patient Name: _____ DOB ___/___/___

(F) **PSYCHOLOGICAL ASSESSMENT**: *(Please check as appropriate)*

Is there any evidence of emotional instability? ☐YES ☐NO Is further examination suggested? ☐YES ☐NO
Does he/she have or has he/she had any episodes of conditions listed below?
Mental Clouding ☐YES ☐NO Blackouts ☐YES ☐NO Dizziness ☐YES ☐NO
Unconsciousness ☐YES ☐NO Convulsions ☐YES ☐NO
If **YES** to any of the above, please explain nature and date of last episode:_____
_____
Diagnosis: _____
_____

(G) Does he/she have any other condition or diseases which would decrease ability to safely operate a motor vehicle? *(Please check as appropriate)* ☐YES ☐NO
If **YES**, please explain: _____
_____

(H) What type(s) and quantities of drugs are being prescribed for the patient? _____
_____
_____

(I) Do any of the above medications affect driving ability? *(Please check as appropriate)* ☐YES ☐NO
If **YES**, please explain: _____
_____

(J) From a medical standpoint, do you feel he/she is capable of operating a vehicle safely? ☐YES ☐NO
If **NO**, please explain: _____
_____
_____

If YES, the treating physician must attest to one of the two below listed statements, as may be applicable, for any person who is subject to loss of consciousness due to disease of the central nervous system.

☐ I hereby certify that I am the treating physician duly, licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's infirmity is under sufficient control to permit him/her to operate a motor vehicle with safety to person and property.

☐ I hereby certify that I am the treating physician, duly licensed to practice medicine and surgery, for the above named individual and that I have been the treating physician for him/her for a period of at least three months, that I am aware of his/her medical history, including his/her history with respect to diseases of the central nervous system, and that such person's disease no longer requires treatment and that such person can reasonably expect to suffer no further losses of consciousness on account of such disease.

(K) How long have you been treating this patient? _____ Date of last examination: ___/___/___

(L) Additional comments: _____
_____
_____

_____ _____
Physician's Name (Printed or typed) Physician's Signature

_____ _____
Address Phone Number

_____ Date: _____

Please mail form to: MEDICAL RECORDS SECTION - DRIVER IMPROVEMENT UNIT - PO Box 698 - Dover, DE 19903-0698
The form may be transmitted by facsimile to: (302) 739-5667 ATTN.: MEDICAL RECORDS SECTION

DEPARTMENT OF EDUCATION

Townsend Building
401 Federal Street Suite 2
Dover, Delaware 19901-3639
http://www.doe.k12.de.us

Mark A. Holodick, Ed.D.
Secretary of Education
Voice: (302) 735-4000
FAX: (302) 739-4654

SPECIAL DRIVER EDUCATION LEARNER'S PERMIT REQUEST FORM

Date of Issue:_____

This is to certify that _____, birthdate _____ is currently enrolled in the Delaware Department of Education approved Driver Education course and has successfully completed the thirty hours of classroom instruction, and may be issued a non-renewable four month Driver Education Learner's Permit by the Division of Motor Vehicles that is **only** valid during the period of time when the applicant is actually under the direct supervision of a State-approved and licensed adapted driving instructor.

SIGNATURES

1. Student _____
2. Driver Education Teacher _____
3. Administrator _____

NOTE:

*This request form must be fully completed in ink or typewritten without erasures or alterations to be valid.
*This request form may be issued upon satisfactory completion of the thirty (30) classroom instructional hours.
*This is **NOT** a substitute for a temporary instruction permit or operator's license.
*This original request form is to be submitted to, and retained by, the Delaware Division of Motor Vehicle.
*This request form is void after thirty (30) days.
*DMV will require the following in order to process this Learner's Permit Request Form:

a. $40.00
b. Birth Certificate
c. Social Security Card/Passport
d. Parent or Legal Guardian

*This "special" Driver Education Learner's Permit is issued to a legally disabled Delaware resident enrolled in a behind-the-wheel course provided through a contractual agreement between a local school district or the Department of Education and the Moss Rehabilitation Center of Philadelphia, PA, or its subcontractor.

Delaware Code, Title 21, Section 2710(k)