DL-180 (3-20)

pennsylvania
DEPARTMENT OF TRANSPORTATION

NON-COMMERCIAL LEARNER'S PERMIT APPLICATION

YOU MUST APPLY IN PERSON

THIS FORM IS VALID FOR 1 YEAR FROM THE DATE OF PHYSICAL EXAMINATION
The physical date may not be more than 6 months prior to your 16th birthday.

DRIVER'S LICENSE NUMBER/I.D. NUMBER: _____

LAST NAME (S)	JR./ETC

FIRST NAME	MIDDLE NAME

DATE OF BIRTH			HEIGHT		SOCIAL SECURITY NUMBER	TELEPHONE NUMBER (8:00A.M. - 4:30P.M.)	EMAIL ADDRESS
MONTH	DAY	YEAR	FEET	INCHES			

EYE COLOR *(Please check one):* ☐ BLUE ☐ BROWN ☐ GREEN ☐ HAZEL ☐ PINK ☐ BLACK ☐ GRAY ☐ DICHROMATIC ☐ OTHER _____

SEX/GENDER DESIGNATION STATEMENT

I, _____ wish the gender designation on my Driver's License/ ID Card to read
PRINT NAME

☐ Male (M) ☐ Female (F) ☐ Non-Binary/Other (X)

I hereby certify under penalty of law that this request for the selected gender designation to appear on my Driver's License/ ID Card accurately reflects my gender identity and is not for any fraudulent or other unlawful purpose.

STREET ADDRESS - *A Post Office Box number may be used only in addition to the actual street address.*	CITY	STATE	ZIP CODE

PERMIT(S) DESIRED: CHECK DESIRED PERMIT(S)	**FEE**	ENTER FEE FOR EACH ITEM CHECKED
☐ CLASS A (Combination Vehicle over 26,000), ☐ CLASS B (Truck or Bus over 26,000) **OR** ☐ CLASS C (Automobile)	$5.00	
☐ CLASS M (Motorcycle) MSEA Fee is included	$15.00	
LICENSE REQUIRED: MUST CHECK ONE	**FEE**	ENTER FEE FOR LICENSE CHECKED
☐ 4-Year Driver's License	$30.50	
☐ 2-Year Driver's License (Age 65 & Over)	$20.00	
Trust Fund Contribution(s) - If you wish to contribute to the Organ Donation Awareness Trust Fund (ODTF) and/or the Veterans' Trust Fund (VTF) check the appropriate box(s) and enter total amount to the right. (see reverse)		ENTER FEE FOR CONTRIBUTIONS HERE
☐ $3.00 to the Organ Donation Trust Fund (ODTF) ☐ $3.00 to the Veterans' Trust Fund (VTF)		
PAID BY: ☐ **Debit/Credit Card** ☐ **Check** ☐ **Money Order** **Payable to PennDOT (PennDOT Driver License Centers do not accept cash.)**	**TOTAL**	**$**

ALL QUESTIONS MUST BE ANSWERED

(Check [✓] Applicable Block)	YES	NO
1. Have you ever held or possessed a Driver's License (DL)/Learner's Permit (LP)/Photo Identification Card (ID) from PA or any other state?.....	☐	☐
If yes, State: ____ DL/LP/ID #: _____ Name if different than above: _____		
State: ____ DL/LP/ID #: _____ Name if different than above: _____		
State: ____ DL/LP/ID #: _____ Name if different than above: _____		
2. Is your right to apply for a license or your privilege to operate a vehicle in this or any other state currently suspended, revoked, or subject to installation of an ignition nterlock device?.....	☐	☐
If yes, give state _____ date_____, and reason _____		
3. Do you have any pending criminal charges or driving violations in this state or any other state which may carry a possible penalty of suspension or revocation of your driver's license or driving privilege?.....	☐	☐
If yes, give state _____ date_____, and reason _____		
4. Do you hold a valid license or ID card from any other state?	☐	☐

AUTHORIZATIONS AND CERTIFICATIONS

☐ **For Veterans wishing to add the Veterans Designation to their Driver's License or ID Card:** I certify under penalty of law that I am a qualified applicant and hereby request it be added to my product. I understand that misrepresentation will result in the cancellation of my driver's license.

☐ I am under the age of 18 years and I hereby request Organ Donor designation on my PA Driver's License. Parent must check consent block on the Parent Guardian Consent Form (DL-180TD). *(Applicants 18 years of age or older will have the opportunity to request Organ Donor designation at the Photo Center at the time they have their photo taken.)*

I acknowledge that receiving a Pennsylvania Permit, License or ID card will cancel or invalidate any Permit, License or ID card from another state. I certify under penalty of law that this information contained herein is true and correct. I hereby authorize the Social Security Administration to release to the Department of Transportation information concerning my Social Security Identification Number for the purpose of identification. I hereby acknowledge this day that I have received notice of the provisions of Section 3709 of the Vehicle Code. (See back for provisions)

WARNING: Misstatement of fact is a misdemeanor of the third degree punishable by a fine of up to $2,500 and/or imprisonment up to 1 year (18 Pa. C.S. Section 4904[b]).

SIGN HERE _____ _____
(APPLICANT'S SIGNATURE IN INK) (DATE)

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FOR OFFICIAL USE ONLY

ALL INFORMATION IN THIS SECTION MUST BE COMPLETED IN FULL BY A HEALTH CARE PROVIDER

Please check any of the following that **WOULD** prevent control of a motor vehicle.

☐ Neurological disorders ☐ Neuropsychiatric disorders ☐ Circulatory disorder ☐ Cardiac disorder ☐ Hypertension
☐ Uncontrolled Epilepsy ☐ Uncontrolled Diabetes ☐ Cognitive Impairment ☐ Alcohol abuse ☐ Drug abuse
☐ Conditions causing repeated lapses of consciousness (e.g. epilepsy, narcolepsy, hysteria, etc.)

Specify: _____ If seizure disorder, date of last seizure: _____

☐ Impairment or Amputation of an appendage. If so, list: _____
☐ Other: _____

NOTE: Any recommendations/additional comments must accompany this certificate on a health care provider's letterhead.

VISION SCREENING **CHECK (✓)** **YES** **NO**

Combined vision is 20/40 or better..... ☐ ☐
Report of Eye Examination (attached)..... ☐ ☐

☐ Qualified Without Restrictions
☐ Qualified With Restrictions
☐ Corrective Lenses ☐ Other: _____

COMPLETE ALL ITEMS		
Uncorrected		Corrected
20/	Right Eye	20/
20/	Left Eye	20/
20/	Both Eyes	20/
R L	Fields	R L

PROVIDER INFORMATION (Please print or type)

PROVIDER'S NAME	SPECIALTY	STATE LICENSE #	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE	FAX		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

Examinee's Signature (SIGN ONLY IN PRESENCE OF PROVIDER) _____ Provider's Signature _____ Physical Date

COMPLETED BY DRIVER LICENSE EXAMINER ONLY

EXAMINER'S DRIVER CERTIFICATION

This is to certify that the above applicant has applied for and passed the examination for the above class(es) for a Pennsylvania Driver's License.

DATE OF ISSUE:		
MONTH	DAY	YEAR

EXAM CENTER: _____

(SIGNATURE OF EXAMINER) _____ (DLE NO.) _____

TO MEET IDENTIFICATION REQUIREMENTS YOU MUST PRESENT THE FOLLOWING:

U.S. Citizens -

Social Security Card (must be original) AND **ONE** of the following:

- Birth Certificate with raised seal (U.S. issued by an authorized government agency, including U.S. territories or Puerto Rico.) **No other birth documents will be accepted.**
- Certificate of U.S. Citizenship **(BCIS/INS Form N-560)**
- Certificate of Naturalization **(BCIS/INS Form N-550 or N-570)**
- Valid U.S. Passport (Only valid U.S. Passports and original documents will be accepted.)

NOTE: If you have an Out-of-State Driver's License, you should present it along with your Social Security Card and one of the above forms.

Non-U.S. Citizens – You must bring ALL of the following:

- Original USCIS/immigration documents indicating current lawful immigration status
- Valid Passport, dependent on status
- Social Security Card or SSA ineligibility letter (must be original; card cannot be laminated)

(Please note: Documents must be original, photo copies will not be accepted.)

To obtain detailed information regarding "identity/residency requirements," you can:

- Visit www.dmv.pa.gov and Enter Search Term "Pub-195NC," and review required documents; or
- Contact us at 717-412-5300. TTY callers - please dial 711 to reach us.

All documents must show the same name and date of birth, or an association between the information on the documents. Additional documentation may be required, if a connection between documents cannot be established (e.g. Marriage Certificate, Court Order of name change, Divorce Decree, etc.)

LEBANON FAMILY HEALTH SERVICES 615 Cumberland Street Lebanon, PA 17042

OUTPATIENT/EMPLOYMENT/DRIVERS LICENSE PHYSICAL MEDICAL FORM

Name _____ **Date** _____

Date of Birth _____ **Age** _____ **Eye Color** _____ **Chart #** _____

Social Security Number _____ **Driver's ID Number** *(if applicable)* _____

Please answer the following questions to the best of your ability:

List any medical conditions or diseases you have:
Indique las condiciones médicas o enfermedades que tienes:

List all medications you take:
Indique todos los medicamentos que tomas:

List dates and causes of hospitalizations, surgeries or other medical procedures: *Indique las fechas y causas de hospitalización, cirugías y otros procedimientos médicos:*	YES *SI*	NO *NO*
1. Do you have any diseases of the nervous system or a brain injury? *Tiene usted un desorden neurológico que prevendría control razonable de un carro?*	☐	☐
2. Do you have any heart or circulation problems such as high blood pressure, Numbness of feet or legs, irregular heartbeat, etc.? *Tiene usted problemas con el Corazón? Problema circulatorios? La hypertension Que prevendría usted se puede controlar un carro?*	☐	☐
3. Do you have any psychological problems that have been treated by a Doctor now or in the past? *Tienes un desorden mental en relación con una enfermedad del sistema nervioso Que le impida conducir?*	☐	☐
4. Do you have Diabetes or high blood sugar? If yes, is it under control with the help of medications and your Doctor? *La Diabetes incontrollable?*	☐	☐
5. Do you have Epilepsy or a seizure disorder? If yes, is it under control with the help of medications and your Doctor? If yes, when was the date of your last seizure: _____ *Hay alguna enfermedad que puede causar fallos repetidos de inconsciencia como la epilepsia, la Narcolepsia o la histeria? La Epilepsia incontrolable?*	☐	☐
6. Do you have limited use or amputation of your legs or arms? *La inmovilidad o la Amputación de las piernas o bracos?*	☐	☐
7. Have you ever lost consciousness more than once? If yes, please list when it happened and why: _____ *Alguna vez ha perdido el conocimiento más de una vez?* *Si dice que si, por favor indique cuando sucedió y por qué.*	☐	☐
8. Do you drink alcoholic beverages? If yes, how much do you drink in a week: _____ *Consume bebidas alcohólicas?*	☐	☐
9. Do you use narcotics or illegal drugs? If yes, what do you use and how often: _____ *Usted utiliza drogas ilegales o narcóticos?* *Si dice que sí, que es lo que utiliza y con qué frecuencia?*	☐	☐
10. Do you have any known allergies to medications or other substances? If yes, what allergies do you have? _____ *Tiene alguna alergia a medicamentos u otras sustancias?*	☐	☐

Patient Signature (Firma) _____ **Date (Fecha)** _____

PATIENT NAME_____ **CHART #**_____

PHYSICAL EXAM

WT_____ HT _____ BMI _____

BP_____ / _____

PULSE _____ RESP_____ TEMP_____

Staff Signature_____ **Date** _____

Education

Method before

Method after

VISION	LUNGS	EXTREMITIES
HEENT	THYROID	SKIN
HEART	ABDOMEN	NEURO/REFLEXES

LABS

Urine:
Long Dip

Urine Drug Screen (eScreen)

MANTOUX/TB _____ L or R
(Patient will need to return to clinic in **48 hours** *to have results read)* RESULTS _____

TETANUS _____ Refer to State Health Department

ASSESSMENT

PLAN

Clinician Signature_____ **Date** _____

KTD/CD 10/16