



DRIVE TO SUCCEED APPLICATION

Student Legal Name: _____

Date of Birth: _____ School Name: _____

Temporary Driver's Permit Number: _____

Full Address (Street Number, Street Name, City, State, Zip Code):

Student Cell Phone Number: _____

Student Email Address: _____

Preferred Licking Valley Driving School Location (please check one):

- Newark Zanesville
 Hebron

Student Eligibility (please check all that apply and provide documentation confirming eligibility):

- School reduced/free lunch participation
 WIC/SNAP household participation
 Medicaid enrollment
 Eligible for one of the above, but not enrolled

Application Requirements:

- Two (2) recommendations from teacher, coach, School Resource Officer, school employee, etc.
- Name 1: _____
Email or Phone Number: _____
Relationship to Student: _____
Signature: _____



Student Name (Print): _____

Student Signature: _____

Date: _____

Parents or Guardians: please complete and sign the affidavit below:

I, _____ (parent/guardian name), confirm that _____ (student name) has not received teen driving education in the state of Ohio. All information in the application and supporting documentation has been provided truthfully. I understand this voucher can only be used at a Licking Valley Driving School location. I understand there will be a \$10 non-refundable fee to participate in the program, paid to the Licking County Health Department via cash, check, or credit card. I understand that if my child does not complete the program or misses scheduled drives, I may be liable for additional fees. I understand my child will be required to provide feedback to the Ohio Department of Public Safety in the form of an online survey. Finally, I consent that my child may participate in this program.

I understand and agree that the Licking County Health Department is in no way a provider of driver education training under the terms of this Agreement and is only providing funding for driver education classes through Licking Valley Driving School through the Drive To Succeed grant received by the Licking County Health Department.

This Agreement is solely for the purposes set forth herein, and shall create no other relationship between myself, my child and the LCHD or Licking County.

I agree to protect, defend, indemnify, and hold LCHD, its officers, employees, and agents, and the Licking County Board of Health free and harmless from and against any and all losses,



penalties, damages, settlements, costs, including but not limited to attorney's fees, or liabilities of every kind and character arising out of or in connection with any acts or omissions, negligent or otherwise, of myself or my child.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____

Parent/Guardian Email: _____

Phone Number: _____ **Date:** _____

The application can be completed electronically but must be hand-signed by each individual named.

Completed application, proof of permit, and proof of student eligibility (financial documentation) can be submitted by:

1. Print and mail to:
Licking County Health Department
ATTN: Drive to Succeed
675 Price Road
Newark, OH 43055
2. Print and drop off at Licking County Health Department (same address as above)
3. Emailed to dts@lickingcohealth.org

Questions should be directed to dts@lickingcohealth.org