LICKING COUNTY HEALTH DEPARTMENT

NEWARK
(740)-349-6535
675 Price Rd.
Newark, OH 43055

PATASKALA
(740) 755-4520
621 W. Broad St.
Pataskala, OH 43062

www.lickingcohealth.org

Drive to Succeed Application – Essay and Affidavit

Student's First and Last Name: _____

Student Essay and Recommendations

Two (2) recommendations from teacher, coach, School Resource Officer, school employee, etc.

- Name 1: _____

  Email or Phone Number: _____

  Relationship to Student: _____

  Signature: _____

- Name 2: _____

  Email or Phone Number: _____

  Relationship to Student: _____

  Signature: _____

Essay Submission (must be 250 words and handwritten): How will driving impact your life?

_____

_____

_____

_____

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Student Name (Print): _____

Student Signature: _____

Date: _____

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Parent/Guardian Affidavit with Signature

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.

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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: _____

Date: _____

This form will be emailed to dts@lickingcohealth.org. Please ensure that the Microsoft Form is also submitted online.