TURNER SCHOOL OF DRIVING, LLC

33487 Harper Avenue • Clinton Township • MI • 48035 • (586) 443 - 6717
State Certification #**P000723** • Office Hours: Sat/Sun: 10:00 a.m. – 2:00 p.m.

Program Number #: _______________ **TEEN SEGMENT 1 CONTRACT** Classroom Location: Clinton Township, MI

Student: (last) (first) (middle)

Address: City: Zip:

Student cell: Student email: Age: D.O.B.:

Parent/Legal Guardian's Name: Parent's/Legal Guardian's Phone #:

Parent/Legal Guardian's Address: City: Zip:

Emergency Contact: Phone #: Parent email:

Dates of Class: (Parent Meeting:Date/Time: :

TEEN SEGMENT 1 PROVISIONS

1. **Turner School of Driving, LLC will provide a minimum of 24 hours of classroom instruction, 6 hours of behind-the-wheel (BTW) instruction and 4 hours of observation time with a certified Michigan Driver Education Instructor.**
2. **Classroom instruction must be a minimum of 3 weeks in length and shall not exceed 2 hours per day. BTW instruction shall not begin until the student has received a minimum of 4 hours of classroom instruction and must be completed no later than 3 weeks after the classroom instruction has been completed.**
3. **Turner School of Driving, LLC will conduct the BTW instruction in a dual-controlled automobile that is insured by the Provider to cover each student enrolled in the program.**
4. **The Student must be at least 14-years and 8-months of age by the first day of a Segment 1 course. Verification by birth certificate is required.**

TEEN SEGMENT 1 TERMS

1. The Parent or Legal Guardian agrees to pay the total amount of $350 on or before the first day of class in the form of; cash or credit card*.
2. The Student and at least one Family Partner must attend the mandatory Parent Meeting.
3. The Student may miss class only for an illness or emergency with documented proof presented to the instructor. The student is required to make up the same class session missed (e.g., The student missed day 5 and must attend day 5 of the next available segment 1 course.)*
4. A fee of $30.00 will be charged if 24 hours advance notice is not given for a driving appointment cancellation.*
5. A fee of $50.00 will be charged for each lost or damaged textbook or workbook.
6. A fee of $10.00 will be charged for each request for a replacement of a Segment One Completion Certificate.

REQUIREMENTS TO PASS THE COURSE

1. The Student must complete all homework and receive an overall grade of 75% on daily quizzes/test.*
2. The Student will be allowed up to three attempts to pass the State Exam, which requires a score of at least 75%* (this is above the requirement of 70%).
3. **The Student must pass ALL BTW Performance Objectives, per the Driver Education Provider and Instructor Act (DEPIA), at the instructor's professional discretion with a satisfactory or higher grade.**

REFUND POLICY

1. Before the beginning of the first class session, all monies will be refunded minus $50 processing fee if no BTW instruction was given.*
2. After the beginning of the first class session, no refund shall be given.*

NOTICE - This provider is required to be certified by the Secretary of State. If you have any complaint that cannot be settled with the provider, please complete the DES-P11 Statement of Complaint form found on the Department of State website; Michigan.gov/DriverEd. Completion of driver education instruction does not guarantee qualification for a driver license.

BTW
WAIVER

Section 33 (d) of the Driver Education Provider and Instructor Act requires that at least two students must be in a vehicle during BTW instruction unless a parent waives this requirement in writing.

I, the Parent/Legal Guardian of the Student, waive this requirement. ☐

I understand that my son/daughter must still complete at least 4 hours of observation time as a passenger in a driver education vehicle being driven by another driver education student.

Date: Student Signature: ______________________________

Date: Parent/Legal Guardian Signature: ______________________________

Date: Turner School of Driving, LLC By: ______________ Owner/President
(EXAMPLE – DO NOT TYPE IN CONTRACT, Provider Name Signature of Provider Owner Title)

ACCOMMODATIONS/MEDICAL CONDITIONS

1. Does the Student require any special accommodations to participate in the classroom phase (e.g., test being read, interpreter, etc.)? Yes ☐ No ☐ If Yes, please explain: ______________________________
2. Does the Student require any special accommodations to participate in the BTW phase (e.g., adaptive devices, interpreter, etc.)? Yes ☐ No ☐ If Yes, please explain: ______________________________
3. Are there any medical conditions that would pose a concern with the Student's BTW instruction (e.g., epilepsy, color blindness, etc.)? Yes ☐ No ☐ If Yes, please explain: ______________________________
4. Is the Student taking any medications that may affect his/her ability to drive a motor vehicle safely? Yes ☐ No ☐ If Yes, please explain: ______________________________
5. Is the Student's visual acuity at least 20/40 corrected? Yes ☐ No ☐
6. In the last six months, has the Student had a fainting spell, blackout, seizure, or other uncontrolled loss of consciousness? Yes ☐ No ☐
7. In the last six months, has the Student had a physical or mental condition which would affect his/her ability to drive a motor vehicle safely? Yes ☐ No ☐

If the answer to any of questions 5 – 7 is Yes, then the Parent/Guardian must provide a letter signed by the Student's physician indicating that the condition has been corrected and/or is under control and the Student meets the physical and mental requirements for a motor vehicle operator's license under Section 309 of the Michigan Vehicle Code, 1949 PA 300, MCL 257.309.

Date: Student Signature: ______________________________

Date: Parent/Legal Guardian Signature: ______________________________

Date: Turner School of Driving, LLC By: ______________ Owner/President
(**EXAMPLE – DO NOT TYPE IN CONTRACT,** Provider Name Signature of Provider Owner Title)

VISION SCREENING TEST

I, ______________________ have been administered a vision screening test on ______________
(SIGNATURE OF STUDENT NAME) (DATE)

by ______________________ and received a visual acuity score of at least 20/40 corrected.
(INSTRUCTOR NAME)

Payment amount: Date(s): Type:

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