



Renewal of Class D (Regular) Driver License By Mail Page 1 of 4

OFFICIAL USE ONLY

Primary ID _____
Secondary ID _____
C - K - M # _____
Amount \$ _____
Date _____ Initials _____

ATTN: Mail-In DL P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.dojmt.gov
• Email: MTMail-MilitaryLicenses@mt.gov • You must use **BLACK** ink to complete this form.

Legal Last Name		Legal First Name		Legal Middle Name		Suffix (<i>Jr., Sr., 1st, etc.</i>)	
Date of Birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Eye Color	Weight	Height	Hair Color	Are you a Montana Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	County #
Montana Residential Address				City		State MT	Zip Code
Montana Mailing Address				City		State MT	Zip Code
Address where your paper and hard copy driver license should be sent (cannot mail out of country)				City		State	Zip Code
Are you a United States Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "No" STOP. You must renew in person.		Place of Birth: City		Place of Birth: State/Province/Country		
Montana Driver License Number		Social Security Number		Email Address		Current Daytime Phone Number	

REGISTER OR UPDATE VOTER REGISTRATION INFORMATION

You can visit the Montana Secretary of State "My Voter Page" to check if you are registered to vote, check your voter registration address, and find the location and directions to your polling place at: <https://app.mt.gov/voterinfo/>.

Your decision to vote or not, and where you submitted this form, will remain confidential.

Do you want to register to vote in Montana or update your voter registration? Yes No

If "No" stop and continue on page 2. If "Yes" continue on.

County you are registering to vote in: _____

Check all that apply: New Registration Name Change Address Change

Are you a citizen of the United States?* Yes No

Will you be at least 18 years of age on or before the next election?* Yes No

Will you be a Montana resident for at least 30 days before the next election?* Yes No

If you checked "No" in response to any of these questions stop and continue on page 2.

Previous Registration Information – will be used to provide cancellation information to former jurisdiction. Required if name changed or if previously registered to vote in another MT county or in another state.

Previous Registration Name		Residence Address of Previous Registration	
Previous City	Previous County	Previous State	Previous Zip Code

Voter Applicant Affirmation

I affirm under penalty of perjury that the information on this application is true, that I am a citizen of the United States, that I will be at least 18 years old on or before the next election, that I will have been a resident of Montana for at least 30 days prior to the next election, and that I am not serving a felony conviction in a penal institution nor have been found to be of unsound mind by a court. I understand that if I have given false information on this application, I may be subject to a fine or imprisonment, or both, under federal and/or state law. By signing you authorize the Motor Vehicle Division to use your electronic signature for voter registration purposes.

Signature* _____ Date* _____

*The affirmation on this application for voter registration must be signed by the applicant. Failure to do so will prevent application from being processed.





Renewal of Class D (Regular) Driver License By Mail Page 2 of 4

Driver License Information

ATTN: Mail-In DL P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.dojmt.gov
• Email: MTMail-MilitaryLicenses@mt.gov • You must use **BLACK** ink to complete this form.

Send this COMPLETED packet (4 pages) along with the following to MVD Attn: Mail-In DL, PO Box 201430, Helena, MT 59620-1430
Check or Money Order made out to the MVD for the appropriate fee, determined by your age **on date of expiration**.

AGE	FEE	With Motorcycle	Years valid	AGE	FEE	With Motorcycle	Years valid
21-67	\$40.50	\$44.50	8	71	\$20.50	\$22.50	4
68	\$35.50	\$39	7	72	\$15.50	\$17	3
69	\$30.50	\$33.50	6	73	\$10.50	\$11.50	2
70	\$25.50	\$28	5	74	\$5.50	\$6	1

If you are going to be 75 or older on date of expiration the fee is \$20.50 (\$22.50 with motorcycle) for 4 years.

- Photocopy** of Primary ID: valid driver license or ID card, certified birth certificate (<http://www.cdc.gov/nchs/w2w.htm>), Montana Federally recognized Indian Tribe ID card, valid military ID, valid US passport or passport card
- Photocopy** of Secondary ID: US Social security card, certified marriage certificate/license, one year expired driver license, valid government employee ID, Medicare/Medicaid or health insurance card with full name and identification number

You can get a complete list of appropriate identification at www.dojmt.gov/driving. You can send 1 primary and 1 secondary, or 2 primary.

CHECK THE TYPE OF LICENSE YOU ARE APPLYING FOR:

Driver License (Class D)

Motorcycle Endorsement

LICENSING QUESTIONS:

1. In the past 10 years, have you held a valid driver license or commercial driver license from any jurisdiction (state) other than Montana? If yes, list all states: _____ Yes No
2. Do you have a current, pending, or previous suspension, revocation, cancellation, disqualification, or withdrawal of your driver license or privilege to drive by the State of Montana or by another state or jurisdiction? > > > > > > Yes No
3. Do you suffer from any chronic or potentially chronic condition that may cause a loss of consciousness or control? Yes No
4. Do you have any physical or mental condition that impairs or may impair your ability to exercise ordinary and reasonable control in the safe operation of a motor vehicle on the highway? > > > > > > > > > > > > Yes No
5. Do you rely on any adaptive equipment or operational restrictions to attain the ability to exercise ordinary and reasonable control in the safe operation of a motor vehicle on the highway? > > > > > > > > > > > > Yes No

OTHER SERVICES OFFERED:

- If you are 15 or older, do you want your driver license or ID to show that you are an organ donor? > > > > > > Yes Not Now
- If you are 18 or older, do you want your driver license or ID to show that you have a living will? > > > > > > > Yes No
- If you are under age 26 but at least age 15, do you consent to registration with the Selective Service System, if required by federal law? (If under 18, you will be registered upon attaining age 18). > > > > > > > > > > > > Yes No

I am a **resident of Montana** (1) presently residing out of the state temporarily and am unable to return to Montana to renew my driver license prior to the expiration date on my driver license, or (2) living in a county that does not provide driver license services: CARTER, GARFIELD, GOLDEN VALLEY, JEFFERSON, JUDITH BASIN, MADISON, PETROLEUM, PRAIRIE, TREASURE, WIBAUX. I certify under penalty of law that the above information and answers are true and correct. I affirm under penalty of law (MCA 61-5-303) that the information on this application is true and correct to the best of my knowledge, information, and belief. I understand that any false or misleading statement on my application may result in criminal prosecution, cancellation of any license or card issued and/or my disqualification for a period of 60 days.

Signature:

Date:



Renewal of Class D (Regular) Driver License By Mail Page 3 of 4

Medical Information

ATTN: Mail-In DL P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.dojmt.gov
 • Email: MTMail-MilitaryLicenses@mt.gov • You must use **BLACK** ink to complete this form.

Legal Last Name	Legal First Name	Legal Middle Name	Suffix (<i>Jr., Sr., 1st, etc.</i>)
Date of Birth (mm/dd/yyyy)	Montana Driver License Number		Phone Number or Email address

INTRODUCTION TO PHYSICIAN:

Montana State Law, MCA 61-5-111(3) (d)(ii), requires a medical evaluation form to be completed by a licensed physician. Pursuant to Montana State Law, MCA 61-5-207, **REEXAMINATION OR MEDICAL EVALUATION – WHEN REQUIRED**, a Montana driver license may be denied if it is determined that additional medical evaluation or license testing is required.

Please indicate, to the best of your knowledge, does the patient display any conditions that could affect the safe operation of a motor vehicle. Complete the sections below. No other paperwork can be used in place of this form, though a separate sheet may be used for unique or additional comments.

Date of Examination: _____ **(This form is valid for six months from this date.)**

1. IMPAIRMENTS THAT ARE PRESENTLY SHOWN BY YOUR PATIENT:

- | | |
|--|---|
| <input type="checkbox"/> Sporadic loss of conscious awareness | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Impaired motor function | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> Reaction, or impairment due to change in medication or dosage | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Neurological or neuromuscular disease | <input type="checkbox"/> Other dementia |
| <input type="checkbox"/> Diminished concentration | <input type="checkbox"/> Other metabolic disorder |
| <input type="checkbox"/> Diminished judgment | <input type="checkbox"/> None |

Comments: _____

2. IS THE PATIENT PHYSICALLY AND MENTALLY CAPABLE OF SAFELY OPERATING A MOTOR VEHICLE, IN YOUR OPINION?

- Yes No

If **NO**, please describe: _____

3. DO YOU RECOMMEND ANY DRIVING RESTRICTIONS OR ADAPTIVE EQUIPMENT FOR THE PATIENT?

- Yes No

If **YES**, please describe: _____

LICENSED PHYSICIAN/PROVIDER:

Signature:	Name (printed):	Date
Type of Practice or Medical Specialty:	Address (include city, state, zip):	Telephone Number:
Medical License Number:		



Renewal of Class D (Regular) Driver License By Mail Page 4 of 4

Eye Specialist Information

ATTN: Mail-In DL P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.dojmt.gov
 • Email: MTMail-MilitaryLicenses@mt.gov • You must use **BLACK** ink to complete this form.

Legal Last Name	Legal First Name	Legal Middle Name	Suffix (Jr., Sr., 1 st , etc.)
Date of Birth	Montana Driver License Number	Phone Number or Email Address	

RELEASE OF INFORMATION BY DRIVER

I authorize eye specialist to answer any questions from the Motor Vehicle Division or its employees relating to my physical or medical condition and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana. I authorize the Motor Vehicle Division to receive any information relating to my physical or medical condition and to use the same in determining whether I have the ability to safely operate a motor vehicle. I affirm under penalty of law (MCA 61-5-303) that the information on this application is true and correct to the best of my knowledge, information and belief.

Signature: _____ Date: _____

INTRODUCTION TO EYE SPECIALIST

The Motor Vehicle Division asks a driver license applicant to visit an eye specialist when the applicant is unable to appear in person for a renewal, unusual eye defects are apparent during tests conducted at an exam station, more accurate measurements are needed, or an improvement in vision would make driving safer. In some cases, examinations by more than one specialist are requested. Driver license examiners do not recommend or suggest health care providers to applicants.

Please complete this form for the examination you conduct. No other paperwork can be used in place of this form. Attach a separate sheet if the case is unique and additional comments are necessary. Only a report from an eye specialist is acceptable. The eye specialist assumes no responsibility in making this report other than that of precisely representing the facts.

Date of Examination: _____ **(This form is valid for six months from this date.)**

Distant Vision Only	Right Eye Only	Left Eye Only	Both Eyes Together	ADDITIONAL COMMENTS:
With Present Correction	/20	/20	/20	
Without Correction	/20	/20	/20	
Best Possible Correction	/20	/20	/20	

1. If Present Correction differs from Best Possible Correction please explain:

2. Is there double vision? No Yes
Describe: _____
3. Is there any evidence of eye disease or injury? No Yes
Explain: _____
4. Is there any difficulty seeing in dim light or at night? No Yes
Explain: _____
5. Any issues above have been corrected? No Yes
Explain: _____

CERTIFICATION OF EYE SPECIALIST

Signature:	Name (printed):	Date:
Type of Practice or Medical Specialty:	Address (include city, state, zip):	Telephone Number:
Medical License Number:		