



Renewal of Class D (Regular) Driver License By Mail Form 1 of 3

OFFICIAL USE ONLY

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

ATTN RNRP P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.dojmt.gov

You must use **BLACK** ink to complete this form

Driver's Legal Last Name		Driver's Legal First Name			Driver's Legal Middle Name			Suffix (Jr, Sr, 1 st , 2 nd , 3 rd)	
Date of Birth (mm/dd/yyyy)	Sex Female Male	Eye Color	Weight	Height	Hair Color	Are you a Montana Resident? Yes No		County #	
Montana Permanent Mailing Address			City			State	Zip Code	New Address Yes No	
Are you a United States Citizen? Yes No	City of Birth			State/ Province/Country of Birth			Social Security Number		
Montana Driver License Number	Email Address					Current Daytime Phone Number			

Send this COMPLETED packet (3 Forms) along with the following to MT Depart. Of Justice, MVD, PO Box 201430, Helena, MT 59620-1430

Check or Money Order made out to the State of Montana 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 (www.vitalcheck.com), 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:

- Class D (Regular Driver License) Motorcycle Endorsement

1. In the past 10 years, have you held a valid driver license or commercial driver license from any jurisdiction (state) other than Montana?

Yes No If YES, list ALL states: _____

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 of 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 to show that you are an organ donor? Yes No

If you are 18 or older, do you want your driver license to show that you have a living will? 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 commercial driver license prior to the expiration date on my commercial 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.

Current Mailing Address (Where Driver License will be sent)

If this is an out of country address only your temporary will be sent here if you send a self-addressed stamp envelope, your permanent license will be sent to your Montana Mailing.

Signature: _____

Date: _____



Medical Evaluation for Driver License Mail Renewal

Form 2 of 3

ATTN: RNRP P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.dojmt.gov

Driver's Legal Last Name		Driver's Legal First Name		Driver's Middle Name		Suffix (Jr, Sr, 1 st , 2 nd , 3 rd)	
Date of Birth		Montana Driver License Number		Phone Number or Email Address			
Montana Mailing Address			City		State	Zip Code	New Address? Yes No
Montana Residential Address			City		State	Zip Code	New Address? Yes No

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, if your patient may have any conditions that could affect the safe operation of a motor vehicle. Complete the sections below and return to patient.

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 | |

Comments: _____

2. IS YOUR 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 YOUR 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:			



Eye Examination for Driver License Mail Renewal

Form 3 of 3

ATTN RNRP P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.dojmt.gov

Legal Last Name	Legal First Name	Legal Middle Name	Suffix (Jr, Sr, 1 st , 2 nd , 3 rd)
Date of Birth	Montana Driver License Number	Phone Number or Email Address	

RELEASE OF INFORMATION BY DRIVER – SIGN IN PRESENCE OF EYE SPECIALIST

I authorize my 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. Leave blank any items not covered during the examination. 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. For proper identification, have the driver sign the report in your presence.

RECORD FOR EXAMINATION

Distant Vision Only	Right Eye Only	Left Eye Only	Both Eyes Together	BREADTH OF VISION FIELD	
With Present Glasses	20/ /	20/ /	20/ /	To Right of Point of Fixation	To Left of Point of Fixation
Without Glasses	20/ /	20/ /	20/ /	_____	_____
Best Possible Correction	20/ /	20/ /	20/ /	Total Angle _____	

Type of instrument used to determine visual acuity: _____ Are you fitting glasses/ contacts for distant vision? No Yes
 Is there double vision? No Yes describe: _____
 Can condition be corrected with glasses? No Yes Other treatment? No Yes Explain: _____
 Are you undertaking such correction or treatment? No Yes Explain: _____
 Is there any evidence of eye disease or injury? No Yes Explain: _____
 Is there any unusual difficulty seeing in dim light or at night? 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:		