



# 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: DLB HQ 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

Driver's Legal Last Name		Driver's Legal First Name		Driver's Legal Middle Name		Suffix (Jr, Sr, 1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> )	
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 Permanent Mailing Address			City		State MT	Zip Code	New Address <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a United States Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> 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 DLB HQ, 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](http://www.vitalcheck.com)), Montana federally recognized Indian Tribal ID card, valid military ID, valid US passport or passport card

**Photocopy** of Secondary ID: US Social security card, certified marriage certificate/license, valid government employee ID, Medicare/Medicaid or health insurance card with full name and identification number, or a Montana driver lincese that is expired one year or less.

You can get a complete list of appropriate identification at [www.dojmt.gov/driving](http://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

- 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: \_\_\_\_\_
- 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
- Do you suffer from any chronic or potentially chronic condition that may cause a loss of consciousness or control?  Yes  No
- 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
- 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 driver license prior to the expiration date on my l widriver 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.

**Temporary** Mailing Address (This is where your permanent driver license will be sent. If out of the country, your permanent will be send to your Montana mailing.)

Signature:

Date:



# Medical Evaluation for Driver License Mail Renewal

Form 2 of 3

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

Driver's Legal <b>Last</b> Name		Driver's Legal <b>First</b> Name		Driver's <b>Middle</b> Name		Suffix (Jr, Sr, 1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> )	
Date of Birth		Montana Driver License Number		Phone Number or Email Address			
Montana <b>Mailing</b> Address			City		State	Zip Code	New Address? Yes No
Montana <b>Residential</b> 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 DLB HQ 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 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> )
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/ /	Total Angle _____	
Best Possible Correction	20/ /	20/ /	20/ /		

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:		