



DC DRIVER LICENSE OR IDENTIFICATION CARD APPLICATION

Please complete all applicable sections of this application

- A. You will be registered with Selective Service if you are 18 - 26 years old. (To opt out, complete separate form)
 B. I would like to be an organ and tissue donor: Yes No C. Do you want to register to vote, update your party, or change your name? Yes No
 (If yes, complete Page 2) If you are updating your address, but do not want your address updated at the Board of Elections, check here.

APPLICANT INFORMATION:

Last Name		First Name		Middle Name		Suffix	
Address		Apt/Unit		City and State		Zip Code	
				Washington, DC			
Date of Birth		Social Security Number		U.S. Citizen		Gender	
MM / DD / YYYY		____ / ____ / ____		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Weight		Height		Eye Color		Hair Color	
LBS.		FT. IN.					
Telephone Number		E-mail Address		Do you need assistance in another language? Which one?			
() -							

TRANSACTION TYPE: (check all that apply)

I am applying for a: Conversion of Out-of-State License to DC License Driver License Provisional License
 Learner Permit Motorcycle Endorsement Identification Card

I already have a DC Driver License or DC Identification Card and applying for: Renewal Duplicate Correction

If Duplicate or Correction, please check all that apply: Name Change Address Change Lost Stolen Damaged
 Other _____

DRIVING HISTORY:

A. Have you ever had a Driver License? Yes No If yes, what jurisdiction/state or country? _____

B. Has your license ever been suspended or revoked? Yes No

C. Has your application for a Driver License been denied in another state or country? Yes No If you answered Yes to questions B or C, provide the date and reason for the suspension, revocation or refusal? _____

D. List other names you have used on a Driver License:
 1. _____ 2. _____ 3. _____

MEDICAL FITNESS: (check all that apply) Skip this section if applying for an Identification Card

In the past 5 years, have you had or been treated for any of the following?

1. Alzheimer's Disease Yes No 2. Insulin Dependent Diabetic Yes No 3. Glaucoma, Cataracts or Eye Disease Yes No

4. Seizure or Loss of Consciousness Yes No (If yes, when was the last seizure)? _____ (Note: Must be seizure free for 12 consecutive months)

5. Do you have other mental or physical conditions that would impair your ability to drive? Yes No

6. Do you require corrective lenses or glasses for the vision screening test? Yes No

7. Are you required to wear a hearing device while driving? Yes No

APPLICANT CERTIFICATION:

Any person using a fictitious name or address and/or knowingly making any false statement on this application is in violation of D.C. Law and subject to a fine of not more than \$1,000 or 180 days imprisonment or both. (D.C. Official Code §22-2405).

I hereby certify, under penalty of perjury, that the information contained on this application is true and correct.

Applicant Signature: _____ **Date:** _____

MATURE DRIVER CERTIFICATION: (Physician's certification required below for applicants 70 years of age and older)

Physician's Name (Please Print)		Physician's Identification Number		Office Phone Number w/Area Code	
Physician's Address (City/State/Zip Code)		E-mail Address			

Based on your medical diagnosis, does the applicant have the ability to safely operate a motor vehicle? Yes No

Physician's Signature: _____ **Date:** _____

Proof of Identity		Out-of-State License Number		Proof of Social Security Number		Proof of Residency	
Official Use Only		Official Use Only		Official Use Only		Official Use Only	
Official Use Only		State	Issuance Date	Exp. Date	Vision Restriction Required	Examiner's Signature and Date	
Official Use Only		Official Use Only		Official Use Only		Official Use Only	



DC VOTER REGISTRATION FORM and INSTRUCTIONS

Please complete all applicable sections of this application

To register to vote, or to update your name or party, complete and sign this form. Your decision to register to vote or not, and where you submitted this form, will remain confidential.
C. Do you want to register to vote, update your party, or change your name? Yes No
(If yes, complete Page 2) If you are updating your address, but do not want your address updated at the Board of Elections, check here.

APPLICANT INFORMATION:

Last Name		First Name		Middle Name	Suffix
Address			Apt/Unit	City and State	Zip Code
				Washington, DC	
Date of Birth	Social Security Number		U.S. Citizen		Gender
MM / DD / YYYY			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone Number			E-mail Address		Do you need assistance in another language? Which one?

Address Where You Get Your Mail (If different from above) Zip Code

Party Registration: To vote in a primary election in the District of Columbia, you must be registered to vote in one of the following four (4) parties (**Check ONE box below**):

- Democratic D.C. Statehood Green Party Republican Libertarian

If you register with "No Party (Independent)" or with another party not listed above, you may not vote in primary elections.

- No Party (Independent) Other (write party name here) _____

If you have a disability and need help with voting, please tell us what type of disability (optional).

Name and address on last voter registration (include county/city/and state if outside D.C.)

Voter Declaration - Read and Sign

Under penalty of perjury, I swear or affirm that I am a U. S. Citizen; I live in the District of Columbia at the address above; I do not claim voting residence outside of the District of Columbia; I am at least 16 years old; I am not in jail for a felony conviction; and I have not been found by a court to be legally incompetent to vote.

WARNING: If you sign this statement even though you know it is untrue, you can be convicted and fined up to \$10,000 and/or jailed for up to five years.

Sign here _____ Date: _____

Clerk	Registration Date	Registration Number

Voter registration information is public with the exception of full/partial social security numbers, dates of birth, email addresses, and phone numbers. In order for your residence and/or mailing address to be kept confidential, you must submit to the Board of Elections' Registrar of Voters a court order directing that such information must be kept confidential.

You are not a registered voter until you receive your voter registration card in the mail.

If you do not receive a voter registration card within three weeks of completing this application, call the Board of Elections at 202-727-2525.

You may also visit our website at www.dcboee.org. Hearing-impaired individuals with TDD, call 202-639-8916.

Información en Español: Si le interesa obtener este formulario en Español, llame 202-727-2525.