Government of the District of Columbia
Department of Motor Vehicles

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** 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	_____/_____/_____	☐ Yes ☐ No	☐Male ☐Female ☐ Unspecified

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._____

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? (If "Yes" to an item, please complete Medical/Eye form.)

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
	State	Issuance Date	Exp. Date	Vision Restriction Required	Employee's Signature and Date
				Official Use Only	Official Use Only

If you have questions, please visit our website at www.dmv.dc.gov or call 311 in DC or 202-737-4404 outside the 202 area code.
To confidentially report waste, fraud or abuse by a DC Government Agency or official, call the DC Inspector General at 1-800-521-1639.

Government of the District of Columbia
BOARD OF ELECTIONS

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	[redacted]/_____	☐ Yes ☐ No	☐ Male ☐ 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 publlc. 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.

To confidentially report waste, fraud, or abuse by a DC Government Agency or official, call the DC Inspector General at 1-800-521-1639.