



GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MOTOR VEHICLES

IGNITION INTERLOCK DEVICE PROGRAM APPLICATION

Visit our website at dmv.dc.gov for additional program requirements and information

APPI	ICA	NT	INF	ORN	ΛAΊ	TION
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ALLEC	AINI	11111	OKM	ATION										
Last Name				First Name					Middle Name			Suffix		
Address							Un	it Num	ber	C	City/State		Zip Code	
										Washington, Do			DC	
Driver L	icens	se Nu	mber	DOB		Telepl	Telephone Number				E-mail			
DRIVER LICENSE HISTORY* (Begin with the most recent operator permit, including learner permit)														
Date Issu									Stat					
					_	-	1 -							
							1							
Цомо мон	Have you ever been convicted for causing injury or death while operating a motor vehicle? ☐ Yes☐ No													
•				an IID progra		•			-	_				
Trave you	раг	пстра	cu III a	iii IID progra	iii witii	iii tiie iasi	11100	(3) y	cars: _	1 1 68		ii yes, wi	iere :	
VIOLATION HISTORY* (Begin with the most recent drug/alcohol related traffic offense)														
						onvicted		Date	Sta		Viola		Co	onvicted
					□Yes□		1				, , , ,		□ Yes □ No	
						es No	1 -						☐ Yes	
VEHICLE INFORMATION* (List all vehicles operated by applicant. Only DC registered vehicles qualify)														
VIN			Ye		J 11	Make			Model		ng Number			
Vehicle 1	**													
Vehicle 2	**													
Vehicle 3	**													
											l .			
SR-22 INSURANCE (Required for the duration of enrollment in the IID program, including extensions)														
Insurance Provider						Policy Number Issue/Expirati				tion Date				
								•					1	
AUTHO	RIZ	ED U	SERS	*** (List all	<u>author</u> i	zed drive	s of	any v	<u>ehicles</u>	<u>list</u> e	ed)			
Last Nam	ne, Si	uffix	Fi	rst Name	Middl	e Name	D	OB	State	L	icense N	umber	Expir	ration Date

^{*}You may attach an additional sheet, if needed

^{**} Supplement form needed if the applicant is not the primary owner

^{***}All authorized users must receive IID training





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OPERATOR CERTIFICATION

I understand that I must have an IID in any vehicle that I operate during the entire time that I am subject to the IID restriction, and that such device must be maintained and calibrated in accordance with DC law. I understand that if I am terminated from or voluntarily leave the IID program my driver license and the vehicle(s) registration will be revoked. I understand that I am responsible for all authorized driver's use of the IID.

I certify that the above information is true and correct to the best of my knowledge, information, and belief. I understand that any false statement in the application may be subject to prosecution under DC law and termination from the IID program.

Signature of Applicant]	Date		
					•					
	EO	D IID X	ENDODO		ONIT	X 7				
FOR IID VENDOR OFFICIAL USE ONLY										
Provider cert	ifies that a device was i	nstalled	on the vehic	cle(s) listed abo	ve and	l all aut	horized	users ha	ive been	
trained on ho	w to use the device.									
	Name of IID Provider					Provid	er Addr	ess		
	Telephone	ephone Number Date								
FOR DMV PERSONNEL USE ONLY										
Is the applicant required to re-test (Knowledge and Road Skills Test)? Yes No										
Is the applica	ant required to re-test (K	nowled	ge and Roac	Skills Test)? [Yes	∐No				
If you come!	ata tha fallowing.									
Date	ete the following: Test	Doto		Test Re			Results			
Date	Test		Results	Date Test				Results		
Employ	yee Name (Print)		Employee	e Signature		Date Operator Number				
2510	(21111)	Employee Name (11mt)						- operat		

Page 2/2 Rev. 7/2015





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IGNITION INTERLOCK DEVICE PROGRAM SUPPLEMENT FORM

Only complete this form if the IID applicant is not the primary registered owner of an authorized vehicle

PRIMARY REGISTERED OWNER (if different from applicant)

Address	11	T '/ NT 1									
Address			City/State		7' 0 1						
	Unit Number		City/State Washington, DC		Zip Code						
Driver License Number	VIN				Number						
Direct Electise realition	VIIV		V C	incic Tag	rumoer						
Telephone Number	Email Address		Preferr	Preferred method of contact?							
			Phone	Phone Mail Email							
IID PROGRAM APPLICANT'S INFORMATION											
IID Applicant's Name (Last w/ Suffix, Firs	t and Middle	IID Applica	nt's DOB	V	ehicle#						
REGISTERED OWNER CERTIFICATION I acknowledge that I am aware of the duration that the applicant is to remain in the IID program. I understand that if the IID program applicant, listed above is terminated or voluntarily leaves the IID program, the registration of my vehicle will be revoked for a minimum of one (1) year or until the end of the applicant's revocation period, which includes extensions. I certify that the above information is true and correct to the best of my knowledge, information, and belief. I understand that any false statement in the application may be subject to prosecution under DC law.											
Signature of Primary C		Date									
FOR DMV PERSONNEL USE ONLY											
Employee Name	Employee Signat	iture	Date	Opei	rator Number						
2111515) 00 1 (01110											