



**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

APPLICANT INFORMATION

Last Name		First Name		Middle Name	Suffix
Address		Unit Number	City/State		Zip Code
Washington, DC					
Driver License Number	DOB	Telephone Number	E-mail		

DRIVER LICENSE HISTORY* (Begin with the most recent operator permit, including learner permit)

Date Issued	State	License Number	Date Issued	State	License Number

Have you ever been convicted for causing injury or death while operating a motor vehicle? Yes No

Have you participated in an IID program within the last five (5) years? Yes No If yes, where? _____

VIOLATION HISTORY* (Begin with the most recent drug/alcohol related traffic offense)

Date	State	Violation	Convicted	Date	State	Violation	Convicted
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

VEHICLE INFORMATION* (List all vehicles operated by applicant. Only DC registered vehicles qualify)

	VIN	Year	Make	Model	Tag Number
Vehicle 1**					
Vehicle 2**					
Vehicle 3**					

SR-22 INSURANCE (Required for the duration of enrollment in the IID program, including extensions)

Insurance Provider	Policy Number	Issue/Expiration Date

AUTHORIZED USERS*** (List all authorized drivers of any vehicles listed)

Last Name, Suffix	First Name	Middle Name	DOB	State	License Number	Expiration 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

FOR IID VENDOR OFFICIAL USE ONLY

Provider certifies that a device was installed on the vehicle(s) listed above and all authorized users have been trained on how to use the device.

Name of IID Provider	IID Provider Address	
Authorized Signature	Telephone Number	Date

FOR DMV PERSONNEL USE ONLY

Is the applicant required to re-test (Knowledge and Road Skills Test)? Yes No

If yes, complete the following:

Date	Test	Results	Date	Test	Results

Employee Name (Print)	Employee Signature	Date	Operator Number



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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)

Last Name		First Name		Middle Name	Suffix
Address			Unit Number	City/State	Zip Code
				Washington, DC	
Driver License Number	VIN			Vehicle Tag Number	
Telephone Number	Email Address			Preferred method of contact?	
				<input type="checkbox"/> Phone <input type="checkbox"/> Mail <input type="checkbox"/> Email	

IID PROGRAM APPLICANT'S INFORMATION

IID Applicant's Name (Last w/ Suffix, First and Middle)	IID Applicant's DOB	Vehicle #

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 Owner	Date

FOR DMV PERSONNEL USE ONLY

Employee Name	Employee Signature	Date	Operator Number