

# WYOMING DRIVER LICENSE/IDENTIFICATION CARD APPLICATION

To be completed by applicant in black ink



Please Print:

Legal Name: (Last) \_\_\_\_\_, (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Box Number or Street City State Zip Code

Residential Address: \_\_\_\_\_  
Number & Street City State Zip Code

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Month Day Year

Place of Birth \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_  
City State Country Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

1. Are you a United States Citizen?  YES  NO (If NO, you must present your valid Immigration documents)
2. Are you a Wyoming Resident?  YES  NO If no, are you:  Active-Duty Military/Dependent  Fulltime WY College Student
3. Within the previous 10 years, list ALL states you have held any type of driver license/permit in: \_\_\_\_\_
4. Do you possess more than one valid driver's license?  YES  NO If YES, where? \_\_\_\_\_
5. Is your current driver license or identification card:  Lost?  Stolen?  Taken by law enforcement?  N/A
6. Is your privilege to drive currently suspended, cancelled, revoked or denied in this or any other state?  YES  NO
7. Do you wish to be an organ or tissue donor?  YES  NO *If under 18 yrs. old, you must have your parent's permission to be a donor.*

The above minor has my permission to be a donor: \_\_\_\_\_ Parent/Guardian Signature

### MEDICAL HISTORY *If further information is necessary, you will be asked to have your doctor complete a Driver Medical Evaluation statement.*

8. Within the previous five year period, have you suffered from or are you under a doctor's care for any of the following:  
Loss or impairment of a limb  YES  NO Loss of consciousness, fainting, or dizzy spells  YES  NO  
Mental or emotional disorder  YES  NO Epilepsy, seizure disorder, seizures, or loss of muscular control  YES  NO
9. Has this condition ever affected your ability to operate a motor vehicle?  YES  NO  
If yes, explain: \_\_\_\_\_
10. Does any medication you take adversely affect your ability to operate a motor vehicle?  YES  NO

### TO BE COMPLETED BY AN APPLICANT FOR A COMMERCIAL LICENSE & NON-COMMERCIAL CLASS "A" & "B"

*Commercial drivers who are non-government employees and drivers who transport intrastate and/or interstate are required to possess a valid Federal DOT Medical card.*

11. Are you applying for a Commercial Driver License & subject to Part 391 of the Fed Motor Carrier Safety regulations?  YES  NO  
If NO (exempt) to Part 391 of the FMCSA regulations, what is your exemption? \_\_\_\_\_
12. Do you possess a valid Federal DOT Medical card?  YES  NO Expiration Date: \_\_\_\_\_  
Examiner verified: DOT card \_\_\_\_\_ DOT waiver \_\_\_\_\_
13. Are you being treated for:  Epilepsy?  Heart Disease?  Insulin Dependent Diabetes?  High Blood Pressure?

Do you consent to the release of your personal information by the Department of Transportation for bulk distribution surveys, marketing or solicitations?  YES  NO

I hereby authorize the release of my driving record to authorized recipients. I hereby certify under penalty of perjury, that the above information is true and correct. I understand that the use of a false or fictitious name; and/or knowingly making a false statement; and/or concealing a material fact in this application may result in a fine or imprisonment or both, and the cancellation of my Wyoming driver license and/or identification card.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Minor's Release: I hereby certify under penalties of law, that I am the legal parent/guardian having custody of the minor and hereby verify that the above information is true and correct. (If parent is not present, a notary must notarize the parents signature above on the back of this form)

### VISION SCREENING (To be completed by a Driver License Examiner or a Vision Specialist)

*CDL drivers must have a visual acuity of at least 20/40 or better in each eye with or without corrective lenses, and at least 70 degrees horizontal field of vision in each eye.*

Visual Acuity: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Both 20/\_\_\_\_  Corrective Lenses  Contacts  Bioptic/Telescopic Lenses  None  
Horizontal Field of Vision: (R): \_\_\_\_\_ degrees (L): \_\_\_\_\_ degrees Total: \_\_\_\_\_ Depth Perception?  YES  NO

Signature of Vision Specialist or Driver Examiner \_\_\_\_\_ Printed Name of Vision Specialist \_\_\_\_\_ Date of Exam \_\_\_\_\_ Phone Number of Vision Specialist \_\_\_\_\_

### \*\*EXAMINER'S USE ONLY\*\*

MVID # \_\_\_\_\_

Verification Document(s): \_\_\_\_\_

Applicant's Driver License or Identification Number: \_\_\_\_\_ State: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Surrendered License/ID for invalidation?  YES  NO Class/Endorsement applied for: \_\_\_\_\_ Service: \_\_\_\_\_

Change of Name/DOB/SSN from previous:  YES  NO If yes, what changed? \_\_\_\_\_

Clearance Verification:  CDLIS PDPS:  ELG/LIC  NOT \_\_\_\_\_ RIS:  CLEAR  NOT  DLN Survey \_\_\_\_\_

TESTING: Written:  Rules of the Road  Motorcycle  Signs/Ctrls Form/Score: \_\_\_\_\_  Attachment \_\_\_\_\_

Skills:  Regular Skills  AltMOST  Re-Exam  CDL Score: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_