



Commercial Driver License Intrastate Medical Waiver Application

If you are a commercial driver and do not meet minimum medical standards, you may use this form to apply for an **intrastate** medical waiver. This form must be filled out by you and your medical examiner. Mail or fax this completed application **with a copy of your physical exam form** to:

CDL Program
 Department of Licensing
 PO Box 9030
 Olympia, WA 98507-9030
 Fax: (360) 570-4915

Allow seven to ten business days for processing. If you have additional questions, please call (360) 902-3619.

PRINT or TYPE Driver name (<i>Last, First, Middle initial</i>)			
Driver license number		Date of birth	
Residence address			
City	State	ZIP code	(Area code) Telephone number
Mailing address			
City	State	ZIP code	
Description of medical condition(s) the waiver is requested for			
Certification <i>I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct. I understand that false statements on this application may result in cancellation of my commercial driving privilege.</i>			
X _____ Signature		_____ Date and place	

Medical--This section must be completed by a licensed medical doctor (MD), a doctor of osteopathy (DO), a board certified psychiatrist (doctor of physical medicine), or an orthopedic surgeon.

PRINT or TYPE Medical examiner name and title			(Area code) Telephone number
Office street address			
City	State	ZIP code	
Certification <i>The above driver's medical condition is not likely to interfere with the ability to safely operate a commercial motor vehicle and is likely to remain stable for:</i> <input type="checkbox"/> <i>the next two years</i> <input type="checkbox"/> <i>other</i> _____ Not more than two years			
X _____ Signature		_____ Date	

For Department Use Only	
CDL License: <input type="checkbox"/> Issued <input type="checkbox"/> Applied for DOT expiration: _____ Waiver expiration: _____	Waiver: <input type="checkbox"/> Approved <input type="checkbox"/> Denied _____ _____ _____ Department signature _____ Date _____