

APPLICATION FOR MAILED NORTH DAKOTA DRIVERS LICENSE, PERMIT, OR IDENTIFICATION

North Dakota Department of Transportation, Drivers License
SFN 61539 (9-2018)

DLN

Date of Birth	FULL NAME	Last	First	Middle
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VISION SFN 2342 attached

Without Glasses/Contacts: L20/ R20/ BOTH 20/	North Dakota Residence Street Address	County in Which You Live								
With Glasses/Contacts: L20/ R20/ BOTH 20/	City or Town	ZIP Code								
<table border="1"> <tr> <td>LEFT</td> <td>T</td> <td>RIGHT</td> <td>T</td> </tr> <tr> <td></td> <td>N</td> <td></td> <td>N</td> </tr> </table>	LEFT	T	RIGHT	T		N		N	Out of State Mailing Address (required for driver's license submission)	
LEFT	T	RIGHT	T							
	N		N							
Color (CDL) <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Email Address (optional - to be used for official correspondence)									
Restriction	Sex	Weight								
Site Number	Height	Color Hair								
Examiner	Color Eyes	Social Security Number								
DATE	1. Under the provisions of the Uniform Anatomical Gift Act, do you wish to be identified as an organ, eye, and tissue donor? <input type="checkbox"/> Yes <input type="checkbox"/> No									
<table border="1"> <tr> <td> </td> <td>/</td> <td> </td> <td>/</td> <td> </td> </tr> </table>		/		/		2. Have you had a North Dakota license, identification card or permit? If yes, list any other names you have used: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No				
	/		/							
	3. Have you held a license, identification card, or permit from any other state or jurisdiction within the past 10 years? If yes, where? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No									
	4. Do you have a history of epilepsy, blackout attacks, or other lapse of consciousness? If yes, give date of last episode: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No									
	5. Do you have a diabetic condition requiring insulin for control? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	6. Do you have a heart condition? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	7. Do you have a mental condition or treatment for a mental condition and your doctor has advised no driving? If yes, explain: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No									
	8. Do you have a physical or medical condition? If yes, list condition and date of diagnosis: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No									

PLEASE SIGN AND DATE BELOW

Protect yourself. If your application contains any false or fraudulent information, your driving privileges will be revoked or canceled. You may also be subject to criminal penalties.
If provided, I acknowledge permission for the Drivers License Division to use my email address for all official correspondence.
I understand that any credentials previously issued by any jurisdiction may be canceled upon issuance of a North Dakota credential.
I certify, under penalty of perjury, that the information hereon is true and correct, and that I do not possess a credential issued by any jurisdiction or have an active license record in any jurisdiction other than noted above, nor are my driving privileges under suspension, revocation, cancellation, or disqualified in any jurisdiction.

Applicant's Signature	Date
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FEDERAL PRIVACY ACT OF 1974
Disclosure of the individual's social security number on this form is mandatory pursuant to NDCC 39-06-03.1 and 39-06-07. The individual's social security number is used by the department for file control purposes and record keeping. If your social security number is not disclosed, we will not issue a permit, license, or identification card.