

Department of Motor Vehicles
Agency of Transportation
dmv.vermont.gov

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23 VSA §1209a(b) allows a person whose license has been suspended for life, to apply for reinstatement of his or her driving privileges under the Total Abstinence Program. If an investigation determines the applicant has abstained for the required number of years, and has successfully completed the required therapy program, the person's license may be reinstated provided the applicant meets any and all other reinstatement requirements. If the applicant has not previously operated under the conditions of an ignition interlock restricted license (RDL) for three (3) years, the Commissioner may impose the additional condition that the person operate under the conditions of an RDL for a period of at least one year following reinstatement. One of those conditions is to drive only those vehicles which are equipped with an Ignition Interlock Device (IID). To properly use an IID, the user must be capable of providing a breath sample size of 1.5 liters. However, the Commissioner may waive this one year requirement if the person furnishes proof that he or she is incapable of using an ignition interlock device because of a medical condition that will persist permanently or at least for one year.

To apply for a medical waiver of the use of an IID, you must complete Section A, and have your physician complete Section B. When both sections have been completed, return this application by mail, or in person, at the address indicated above. Your request will be reviewed and you will be notified, in writing, if your waiver request has been approved.

Section A – To Be Completed By Applicant	
Applicant's Name	
Applicant's Mailing Address – Street / Road / Box Number	
City / State / Zip Code	
Physical Address – If Different From Mailing Address	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Social Security Number	Vermont License/ID Number
I certify that the information contained herein is true, complete and correct to the best of my knowledge. Statements and warrants made herein are certified under penalty of 23 VSA §202 and §203.	
Applicant's Signature:	

Medical Examiner Section on Next Page

Section B – To Be Completed By Medical Examiner

1. The patient/applicant has been under my care for _____ years.
2. Due to a medical condition, the patient's capability of providing a breath sample is limited to the size of: _____ liters.
3. The patient's medical condition is:
- Permanent. One that will persist for at least one year.

I certify that the information contained herein is true, complete and correct to the best of my knowledge. Statements and warrants made herein are certified under penalty of 23 VSA §202 and §203.

Date of Exam	DATE OF EXAM MUST BE WITHIN THE LAST <u>6 MONTHS</u> TO BE ACCEPTABLE.
Medical Examiner's Signature	Date
Medical Examiner's Name (Print Clearly)	Phone Number
Medical Examiner's Mailing Address – Street / Road / Box Number	
City / State / Zip Code	
Classification or Specialty	Title
License State	License Number