WASHINGTON STATE DEPARTMENT OF LICENSING

Ignition Interlock Device Tolling Medical Exemption

Use this form to provide us with information regarding a driver's ability to operate an ignition interlock device (IID). A driver who is unable to operate an IID may be exempt from IID tolling requirements, but will not be granted driving privileges.

Mail or fax completed report to:

Restricted Licensing
Department of Licensing
PO Box 9030
Olympia, WA 98507
(360) 570-7893

Driver/Patient information – Complete this section and sign the consent to release information.

Name *(Last, First, Middle)*			Driver license number
Date of birth *(mm/dd/yyyy)*	(Area code) Daytime phone number	Email address	

Consent to release information

I authorize the approved licensed MD, DO, RN, ARNP, or PA below to provide information regarding my medical condition from an examination ***done in the past 30 days****. I understand the Department of Licensing will use this information to arrive at a decision regarding my ability to operate an ignition interlock device.*

Date _____ X **When you have completed this form, print it out and sign here.** _____ Driver signature

Medical provider – MD, DO, RN, ARNP, or PA ONLY – Complete this section and return to Department of Licensing

The above-named driver is applying to the Department of Licensing for a medical exemption from their ignition interlock device (IID) tolling requirements. This exemption is for a person who is unable to operate an IID based on a physical disability. Exemptions may be approved for up to one year at a time. Your knowledge of this person's condition is of great value in assisting us to make a proper decision.

To operate an IID, the individual must be able to provide a minimum breath sample of 1500 ml or 1.5 L of breath.

Date of examination **(within last 30 days)**

Answer the following

1. Based on this examination, is this person able to meet the minimum breath sample requirements for the operation of an ignition interlock device? . . . . . ☐ Yes ☐ No

   If "No," what is your recommended exemption period for the above-named patient: *(select one)*
   ☐ 1 year
   ☐ Temporary until: _____ (up to 1 year)
   Date

Medical provider name		Professional credential	Professional license number
Address *(Street address, City, State, ZIP code)*			
(Area code) Phone number	(Area code) Fax number	Email address	

I certify under penalty of perjury under the law of Washington that the information I have provided is true and correct.

Date and place (city or county) signed _____ X **Medical provider signs here.** _____ Medical provider signature (MD, DO, RN, ARNP, or PA **ONLY**)

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WAC 204-50-110; 308-107-090