

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

120 State Street
Montpelier, Vermont 05603-0001
802.828.2061
Toll Free: 888-99-VERMONT
TTD: 711

To properly use an Ignition Interlock Device, you must be capable of providing a breath sample of 1.5 liters. To lower the required breath sample needed to operate your device, complete section A, and have your physician complete section B.

When both sections have been completed, return this application by mail, or in person, to 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	Vermont License/ID Number
Social Security Number	Are you applying for the Total Abstinence Reinstatement <input type="checkbox"/> Yes <input type="checkbox"/> No	
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: _____ 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 6 MONTHS 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