WASHINGTON STATE DEPARTMENT OF LICENSING

Commercial Driver License
Intrastate Medical Waiver Application

Use this form to apply for an **intrastate** medical waiver if you have or are applying for a commercial driver license (CDL) and do not meet the minimum federal medical/vision standards. This form is not for drivers that do not have a CDL. For questions about your drive record we suggest you check your driving status online at dol.wa.gov.

Send this form and a complete copy of your most current Medical Examination Report (the DOT medical card is not sufficient) to:

CDL Medical Unit
Department of Licensing
PO Box 9030
Olympia, WA 98507-9030

Email: CDLMED@dol.wa.gov (only CDL medical forms are accepted at this email address)
Fax: (360) 570-4915

Allow 7-10 business days for processing. Incomplete applications will not be processed.

PRINT or TYPE Driver name *(Last, First, Middle initial)*		
Driver license number	Date of birth	(Area code) Phone number
Describe the disqualifying medical condition(s) for this waiver		

Certification
I certify under penalty of perjury under the law 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.

X **When completed, print this out and sign here.**
Signature Date

Medical examiners use only–This section must be completed by a licensed medical professional listed on the National Registry of Certified Medical Examiners.
Find a certified medical examiner at https://www.fmcsa.dot.gov/medical/driver-medical-requirements/national-registry-certified-medical-examiners.

PRINT or TYPE Medical examiner name		
Office street address		
City	State	ZIP code
National Registry number		
(Area code) Phone number	Professional license number	

Certification
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: ☐ *the next two years* ☐ *other* _____
Not more than two years

X **Medical examiner signs here.**
Medical examiner signature Date

Title