



Commercial Driver License Intrastate Medical Waiver Removal Application

Use this form to apply to have an **intrastate** medical waiver removed.
If you no longer need the medical waiver and now meet the minimum federal medical/vision standards, send this form and a copy of your complete Medical Examination Report 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.

For questions about your drive record we suggest you check your driving status online at dol.wa.gov.
A new license issuance will be required to remove the intrastate and medical variance restrictions.
Fees for a new license will apply.

PRINT or TYPE Driver name <i>(Last, First, Middle initial)</i>		
Driver license number	Date of birth	(Area code) Phone number
Describe the disqualifying medical condition(s) that you no longer have and no longer need an intrastate medical waiver for		
Certification <i>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.</i>		
X _____ 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 <i>The above driver no longer has any disqualifying medical conditions likely to interfere with the ability to safely operate a commercial motor vehicle and no longer needs an intrastate medical waiver for the medical conditions listed.</i>		
X _____ Medical examiner signature		_____ Date
_____ Title		