REQUEST TO RENEW OR OBTAIN DUPLICATE
DRIVER LICENSE/IDENTIFICATION CARD BY MAIL
DUE TO MEDICAL CONDITIONS
CI-1 Rev. 9-14

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
MAIL-IN LICENSE TRANSACTION UNIT
60 STATE STREET, WETHERSFIELD, CT 06161-5056
On the Web at: ct.gov/dmv
Telephone: (860)263-5148
Fax: (860)263-5591

INSTRUCTIONS:

1. PART A must be completed by applicant.
2. PART B must be completed by a licensed physician. The applicant must return this form by mail to the address above. This form must be submitted with the Request for a Connecticut Driver's License/Identification Card by Mail (B-350).
3. Physicians (IMPORTANT): If the applicant's medical condition is a chronic health problem which in your judgment will significantly affect his or her ability to safely operate a motor vehicle, or the applicant has recurrent periods of unconsciousness uncontrolled by medical treatment, and the applicant is attempting to RENEW or OBTAIN A DUPLICATE OF HIS or HER DRIVER LICENSE do not use this form.

   Connecticut General Statutes Section 14-46 allows any physician to report to the Department of Motor Vehicles in writing the name, age and address of any person diagnosed to have a chronic health problem which in such physician's judgment will significantly affect the applicant's ability to safely operate a motor vehicle. The Department of Motor Vehicles will accept notification by:

   a. a letter from the physician on his or her business letterhead stating the applicant can no longer safely operate a motor vehicle due to their health problem

   b. Affidavit to Report a Driver Who May be Unable to Safely Operate a Motor Vehicle (P244). This form must be notarized and may be downloaded at: http://www.ct.gov/dmv

If you are unable to appear in person to obtain a duplicate or renew your Connecticut driver's license/identification card due to a medical condition the information below must be provided to the DMV and certified by a licensed physician. NOTE: If you are no longer a resident of the State of Connecticut your Connecticut driver's license/identification card must be turned in and a new license/identification card must be applied for in the state in which you currently reside.

PART A - COMPLETED BY APPLICANT

NAME OF PERSON WHO IS REQUESTING TO RENEW LICENSE/ID BY MAIL	DATE OF BIRTH	DRIVER'S LICENSE/IDENTIFICATION CARD NUMBER *(If Known)*

DAYTIME TELEPHONE NUMBER	ADDRESS

E-MAIL ADDRESS	APPLICANT: MAY WE CONTACT YOU VIA E-MAIL REGARDING YOUR REQUEST, IF NECESSARY?
	☐ YES ☐ NO

I swear or affirm under penalty of false statement in accordance with the provision of section 14-110 and 53a-157b of the Connecticut General Statutes, that I am unable to appear in person at this time to renew my Connecticut driver license/identification card due to my current medical condition. I understand that if I make a statement which I do not believe to be true, with the intent to mislead the commissioner, I will be subject to prosecution under the above-cited laws.

APPLICANT SIGNATURE	DATE SIGNED
X	

PART B - COMPLETED BY PHYSICIAN

Physicians: By completing and signing the section below, you are certifying under penalty of false statement that the above applicant is currently and temporarily unable to physically appear at an authorized DMV office/location to renew their license in person due to a medical condition.

PHYSICIAN'S NAME	MEDICAL LICENSE NUMBER	LICENSING STATE

OFFICE ADDRESS

OFFICE TELEPHONE NUMBER	OFFICE E-MAIL

PHYSICIAN: MAY WE CONTACT YOU VIA E-MAIL TO VERIFY YOUR SIGNATURE?	CONDITION IS TEMPORARY	IF YES, ESTIMATE DATE OF RECOVERY
☐ YES ☐ NO	☐ YES ☐ NO	

I swear and affirm under penalty of false statement in accordance with the provisions of section 14-110 and 53a-157b of the Connecticut General Statutes that the applicant listed above is currently under my care and is medically unable to appear in person to renew his/her license at this time. I understand that if I make a statement which I do not believe to be true, with the intent to mislead the commissioner, I will be subject to prosecution under the cited-laws.

SIGNATURE OF PHYSICIAN	DATE SIGNED
X	