STATE OF ALASKA - DIVISION OF MOTOR VEHICLES

Anchorage Driver Services
4001 Ingra Street, Suite 101
Anchorage, AK 99503
Email: doa.dmv.limited@alaska.gov

MANDATORY INSURANCE SUSPENSION NON-COMMERCIAL LIMITED LICENSE APPLICATION

GENERAL INFORMATION: Mail, deliver or e-mail the completed application to the address shown above. Failure to complete all the necessary sections of the application will delay your limited license. You may be eligible for a limited license to use for work or medical care purposes if you have not been previously suspended for Failure to Maintain Mandatory Insurance in the previous 10 years. AS 28.22.041(c)(2) You must surrender your driver's license along with this application unless the license was previously surrendered. If you are under 18 years of age a Parental Consent form either notarized or witnessed by a DMV employee is required to be submitted with this application. For further information please call (907) 269-5551 to speak with a customer service representative. Form must be completed in blue or black ink.

SECTION I: MUST BE COMPLETED BY THE APPLICANT

1. Name: _____
   First Middle Last
2. Mailing Address: _____
   P.O. Box or Street City State Zip
3. Residence Address: _____
   Street City State Zip
4. Birth Date: _____ Driver's License Number: _____ Phone Number: _____
5. Why would using public transportation, carpooling or other methods of transportation put an undue hardship on your ability to earn a livelihood? _____
   _____
   _____
6. Check below why limited driving privileges are required.
   ☐ To drive to and from the Residence and Work addresses shown below by the most direct route.
   Residence Address: _____
   Street City State Zip
   Work Address: _____
   Street City State Zip
   ☐ To drive to and from medical appointments by the most direct route.
   If the medical appointments are for your dependent provide their name and relationship to you.
   Dependent Name: _____ Relationship to you: _____

SECTION II: MUST BE COMPLETED BY MEDICAL PROVIDER FOR MEDICAL APPOINTMENTS

To be completed by medical care provider if limited driving privileges for medical care is requested.

7. I certify that _____ has medical appointments described below scheduled with
   Dr. _____ located at _____
   Street Address City
   I certify that I am authorized to verify medical care appointments for the doctor listed above.
8. Authorized Signature: _____ Title: _____ Date: _____
9. Printed Authorized Name: _____ Contact Phone Number: _____
10. Appointment Date(s) and Time(s): *Be specific, as generalities will cause the application to be rejected. If necessary attach a separate sheet.

_____
_____
_____

SECTION III: VERIFICATION OF EMPLOYMENT- MUST BE COMPLETED BY EMPLOYER

If limited driving privileges are required for work purposes this section must be completed by your employer. Separate application forms are required for each employer that limited driving privileges will be needed for work purposes. If you are self-employed you will need to complete this section and submit a copy of your current business license.

11. Name of Business: _____

12. Street Address of employee's work station: _____

13. I certify that I am authorized to verify employment for the above company, and that the person named on the front of this application is currently employed by this company and is scheduled to work the following schedule.

14. List the days of the week the employee will be working: _____

15. Work day starts at: _____am/pm Work day ends: _____am/pm

***In accordance with 2 AAC 90.530(d) total drive time cannot exceed 12 hours per day, including drive time to and from employment or for medical appointments.**

16. Please explain the reason for a non-traditional or varied work schedule. A defined work schedule is required, insufficient work schedule information will cause the application to be rejected. _____

_____

_____

17. Is the employee required to drive at work? ☐ Yes ☐ No If the employee drives at work complete the below certification is required. Driving vehicles that require a CDL is prohibited.)

18. I certify _____ is authorized to:
Employee Name

☐ Yes ☐ No Drive a private vehicle for company business within the hours listed above.

☐ Yes ☐ No Drive company vehicle(s) for company business within the hours listed above.

19. Authorized Employer's Signature: _____ Title: _____ Date: _____

20. Print Authorizing Name: _____ Office Phone Number: _____

SECTION IV: APPLICANT STATEMENT AND SIGNATURE

21. I hereby certify all statements made in this application are true. I agree and understand any misstatement of material facts herein may cause cancellation and/or denial of the limited license pursuant to AS 28.15.161. I agree and understand that violating the terms of the limited license will result in the cancellation of the limited license. I understand that I must be covered by liability automobile insurance in all vehicles I drive. I understand that commercial motor vehicles that require a Commercial Driver's License cannot be driven on a limited license pursuant to AS 28.33.140(f).
I understand that, if the application is completed properly and all the requirements have been met, the processing and issuance of a limited license requires 10 business days from the date of receipt by Anchorage Driver Services.

22. The following required items are included with my application to obtain a limited license for work purposes:

☐ Parental Consent (If under 18 years of age) ☐ Copy of Medical Appointment Schedule (if required)

☐ Copy of current business license (if self-employed) ☐ Copy of SR-22 insurance filing (dated within 30 days)

☐ Last Issued Driver's License OR explaination why you do not have the license to surrender. _____

_____

_____

23. Applicant's Signature: _____ Date: _____