

## APPLICATION FOR CRITICAL NEED RESTRICTION [Section 13353.8(a) VC]



**Submit COMPLETED** application to the **Driver Safety Actions Unit, 2570 24<sup>th</sup> Street, M/S J256, Sacramento, CA 95818, Telephone: (916) 657-6452.** DMV approval is required prior to issuance of a restricted license. If approved, a \$100 reissue fee must be paid and a California Insurance Proof Certificate (SR-22) must be submitted to the department prior to issuance of a restricted license; proof of financial responsibility must be maintained for three (3) years. Do not present in person at any DMV field office. **ATTACH SEPARATE SHEET IF MORE SPACE IS NEEDED.** Incomplete information may delay the issuance of this license. Application can only be approved if driver is legally present in California and specific **HARDSHIP** conditions are shown to exist. **ALL** other transportation must be inadequate. Action taken by the department must be pursuant to § 13353.2 & 13388 of the Vehicle Code **AND** applicant must have been under 21 years of age at the time of arrest/detainment and have submitted to a Preliminary Alcohol Screening test, or other chemical test, as requested by a peace officer. A 30 day mandatory suspension is required prior to issuance of a hardship license.

### I. STATEMENT OF FACTS BY APPLICANT (OR PARENTS, IF UNDER 18 YEARS OF AGE)

CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR APPLICATION AND COMPLETE THE CORRESPONDING SECTION(S): A, B, C, OR D

A.  For Family Illness      B.  To and From School      C.  To and From Work      D.  For Family Enterprise

APPLICANT'S FULL NAME	DL NUMBER	DATE OF BIRTH	HOME PHONE (    )    (    )	DAY PHONE (    )    (    )
STREET ADDRESS AND CROSS STREET	CITY		ZIP CODE	

### DESCRIPTION OF CURRENT TRANSPORTATION AND NEEDS

LIST APPLICANT'S ESSENTIAL DRIVING NEEDS

DISTANCE FROM APPLICANT'S RESIDENCE TO NEAREST PUBLIC TRANSPORTATION	DESCRIBE BEST TRANSPORTATION ROUTE, COMPANY NAME, TELEPHONE NO., NO. OF INDIVIDUAL LINES
--	--

LIST NAMES AND DRIVER LICENSE NUMBERS OF ALL DRIVERS IN THE HOUSEHOLD

EXPLAIN SPECIFICALLY WHY EACH DRIVER IN THE HOUSEHOLD CANNOT DO THE REQUIRED DRIVING. INCLUDE DAILY WORK OR SCHOOL AND TRAVEL SCHEDULE OF EACH DRIVER, HOURS AND LOCATION OF EMPLOYMENT, DISTANCE FROM HOME AND APPLICANT'S SCHOOL. INCLUDE NUMBER OF EMPLOYEES IF SELF EMPLOYED. USE SEPARATE SHEET IF NECESSARY

IF HOUSEHOLD INCLUDES NON-DRIVING ADULT OR MINOR OLDER THAN APPLICANT, GIVE NAME AND RELATIONSHIP TO APPLICANT AND EXPLAIN WHY PERSON CANNOT/DOES NOT DRIVE. (IF MEDICAL REASON, SEPARATE STATEMENT OF FACTS BY PHYSICIAN NEEDED.)

EXPLAIN WHY CARPOOLS, TAXIS, BICYCLES, WALKING, VANPOOLS AND ANY OTHER PRIVATE TRANSPORTATION CANNOT BE USED.

### A. ADDITIONAL INFORMATION REQUIRED IF REQUEST IS DUE TO FAMILY ILLNESS

RELATIONSHIP BETWEEN THE ILL PERSON AND THE APPLICANT	DOES THIS ILLNESS PREVENT THIS PERSON FROM DRIVING AND FOR HOW LONG? <input type="checkbox"/> Yes If yes, how long? <input type="checkbox"/> No
---	--

DESCRIBE CURRENT TRANSPORTATION ARRANGEMENTS

### B. ADDITIONAL INFORMATION REQUIRED IF REQUEST IS BASED ON NEED FOR TRANSPORTATION TO AND FROM SCHOOL

CHECK APPROPRIATE BOX <input type="checkbox"/> High School <input type="checkbox"/> College/University <input type="checkbox"/> Other:	DESCRIBE CURRENT TRANSPORTATION ARRANGEMENTS
---	--

EXPLAIN THE CIRCUMSTANCES THAT NOW MAKE THE APPLICANT'S OPERATION OF A MOTOR VEHICLE ESSENTIAL

### C. ADDITIONAL INFORMATION REQUIRED IF REQUEST IS BASED ON NEED FOR TRANSPORTATION TO AND FROM WORK

EXPLAIN CIRCUMSTANCES THAT NOW MAKE APPLICANT'S INCOME ESSENTIAL IN THE SUPPORT OF THE FAMILY

APPLICANT'S NET OR TAKE HOME INCOME \$                      Per	NUMBER OF PEOPLE IN HOUSEHOLD	DESCRIBE USE OF APPLICANT'S INCOME	TOTAL FAMILY NET OR TAKE HOME INCOME \$                      Per
--	-------------------------------	------------------------------------	---

### D. ADDITIONAL INFORMATION REQUIRED IF REQUEST IS BASED ON FAMILY ENTERPRISE

NAME AND ADDRESS OF ENTERPRISE

NATURE AND TYPE OF ENTERPRISE	YEARS IN BUSINESS	NUMBER OF EMPLOYEES (INCLUDE FAMILY MEMBERS)
-------------------------------	-------------------	--

EXPLAIN SPECIFICALLY WHY EACH EMPLOYEE CANNOT DO THE REQUESTED DRIVING. INCLUDE DAILY WORK AND TRAVEL SCHEDULE OF EACH EMPLOYEE

California Relay Telephone Service for the deaf or hearing impaired from TDD Phones: 1-800-735-2929; from Voice Phones: 1-800-735-2922

EXPLAIN WHY SOMEONE CANNOT BE EMPLOYED TO DO THE REQUESTED DRIVING

EXPLAIN WHY APPLICANT'S OPERATION OF A MOTOR VEHICLE IS NECESSARY TO THE ENTERPRISE

HOURS PER WEEK APPLICANT WOULD WORK

SALARY (IF ANY)

**AUTHORIZATION AND CERTIFICATION:** (If under 18 years of age, both parents must sign)

I/We hereby authorize the Department of Motor Vehicles to ask for and receive any additional information needed to determine eligibility for a critical need restriction from physician, school principal and/or employer certifying to a Statement of Facts. Medical information is confidential under Section 1808.5 VC.

**I/We hereby certify, under penalty of perjury under the laws of the State of California, that all statements on this application are true (Perjury is punishable by imprisonment or fine or both.) Both parents must sign unless one has custody and writes: "I have sole custody."**

APPLICANT'S SIGNATURE <b>X</b>	DATE	ADDRESS	CITY	ZIP
FATHER'S SIGNATURE <b>X</b>	DATE	ADDRESS	CITY	ZIP
MOTHER'S SIGNATURE <b>X</b>	DATE	ADDRESS	CITY	ZIP

**II. PHYSICIAN MUST COMPLETE** a separate Statement of Facts (II) for each family member whose disability affects driving or transportation needs.

**STATEMENT OF FACTS BY PHYSICIAN**

NAME OF PATIENT	DIAGNOSIS
MEDICAL CONDITION(S) AND SYMPTOM(S)	
PROGNOSIS (INCLUDE PROBABLE DATE WHEN SUFFICIENT RECOVERY WILL HAVE BEEN MADE TO TERMINATE THE EMERGENCY. IF CONDITION IS CHRONIC, PHYSICIAN MUST STATE THAT FACT)	
DOES PATIENT'S CONDITION RULE OUT DRIVING? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Permanently <input type="checkbox"/> Temporary-how long?	DOES PATIENT'S CONDITION RULE OUT USE OF PUBLIC TRANSPORTATION? INCLUDING PARATRANSIT (CURB TO CURB SERVICE) <input type="checkbox"/> Yes <input type="checkbox"/> No

**III. SCHOOL PRINCIPAL OR DEAN MUST COMPLETE** a Statement of Facts (III) if hardship condition is to and from school. If hardship condition is to and from college, submit a printout of current schedule, including days and hours of all classes in which enrolled.

STUDENT'S NAME	LENGTH OF ATTENDANCE	STUDENT'S DAILY SCHOOL HOURS	
EXPLAIN WHY SCHOOL AND OTHER TRANSPORTATION IS INADEQUATE FOR REGULAR ATTENDANCE AT SCHOOL AND ACTIVITIES AUTHORIZED BY THE SCHOOL			
NAME AND ADDRESS OF SCHOOL	NAME OF SCHOOL DISTRICT		
DISTANCE: RESIDENCE TO SCHOOL	TO SCHOOL BUS STOP (if any)	SCHOOL TO PUBLIC TRANSPORTATION	LAST DAY OF STUDENT'S SCHOOL YEAR

**IV. EMPLOYER MUST COMPLETE** a Statement of Facts (IV) if hardship condition is to and from work.

NAME OF EMPLOYEE AND NAME OF ESTABLISHMENT OR BUSINESS	DATE OF EMPLOYMENT	SALARY \$ Per			
ADDRESS AND CROSS STREET OF PLACE WHERE APPLICANT REPORTS TO WORK					
TYPE OR NATURE OF EMPLOYMENT	WORK HOURS (STARTING & ENDING TIMES):	MONDAY THRU FRIDAY	SATURDAY	SUNDAY	WEEKLY TOTAL
PERMIT TO EMPLOY MINOR ON FILE? IF YES, GIVE NAME, TITLE AND TELEPHONE NO. OF ISSUING PARTY.					EXPIRATION DATE
<input type="checkbox"/> Yes <input type="checkbox"/> No					
DISTANCE FROM APPLICANT'S RESIDENCE TO PLACE OF EMPLOYMENT			DISTANCE FROM PLACE OF EMPLOYMENT TO PUBLIC TRANSPORTATION		

**V. CERTIFICATION TO BE COMPLETED BY:**  Physician  School Principal or Dean  Employer

**I certify, under penalty of perjury under the laws of the State of California, that the above statements are true. (Perjury is punishable by imprisonment or fine or both.)** This section may be duplicated, if necessary, to accommodate certification by more than one party.

NAME OF SIGNER (PRINT OR TYPE)	TITLE	
ADDRESS	CITY	ZIP
SIGNATURE <b>X</b>	DATE	TELEPHONE NUMBER ( )

For further information, contact the Driver Safety Actions Unit at (916) 657-6452, or from the DMV website at: <http://www.dmv.ca.gov/>