



Ignition Interlock Limited License

Driver Information

 Driver's License Number State of Issue

 First Name Middle Name Last Name

 Address City/State/Zip

 Phone Number Date of Birth Date of Application

Limited License Information

Indicate the days and times you are requesting to drive. Make sure to indicate A.M. or P.M. A limited license cannot be issued for more than *six (6) days and 60 hours* per week for work, school, or child care needs with one specific day of no driving. You must specify days and hours on any of the items listed below or it will not be written on the limited license.

You must choose one day that you will **NOT** drive. I will NOT drive on _____ (enter day of week).

 Place of Employment Address City/State/Zip Occupation

 Applicant's Postsecondary Education Address City/State/Zip

 Child Care (custodial parents only) Address City/State/Zip

DAY of WEEK	TO WORK/SCHOOL/CHILD CARE		JOB RELATED DRIVING TIME OTHER THAN TO AND FROM	TO HOME	
	Depart	Arrive		Depart	Arrive
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

Tennessee Warning – Information collected on this form is used by the Department of Public Safety (DPS) to identify the person and as required by Minnesota Statute. If you do not provide this information, DPS cannot enroll you in the Ignition Interlock Device Program. Personal information (name and address of individuals) is classified as private data. DPS releases this information only as authorized or required by state and federal law.

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Other allowable driving (include travel time)

Court Appearances (must be related to the alcohol offense)

Address of Court House _____ City/State/Zip _____

Date of Appearance: _____ Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

Date of Appearance: _____ Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

Meeting with Probation Officer and/or DWI Court (MUST SPECIFY EXACT DATES AND TIMES)

Address _____ City/State/Zip _____

Date: _____ Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

Date: _____ Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

Chemical Dependency Treatment and/or Programs

Name of Treatment Facility _____ Address _____ City/State/Zip _____

Check day(s): Su M Tu W Th F Sa Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

Abstinence-based Support Group Meeting (up to a maximum of 3 support group meetings a week allowed)

Name of Support Group(s) _____ Address _____ City/State/Zip _____

Check day(s): Su M Tu W Th F Sa Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

Check day(s): Su M Tu W Th F Sa Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

Check day(s): Su M Tu W Th F Sa Leave Home _____ A.M. P.M. Return Home _____ A.M. P.M.

FAX to: (651) 797-1299

EMAIL to: dvs.ii@state.mn.us

MAIL to: Driver and Vehicle Services, Ignition Interlock Unit, 445 Minnesota St., Suite 177, St. Paul, MN 55101

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