



**GOVERNMENT OF THE VIRGIN ISLANDS  
OF THE UNITED STATES OFFICE OF THE GOVERNOR  
BUREAU OF MOTOR VEHICLES**



**APPLICATION FOR FIRST TIME VI DRIVER'S LICENSE MEDICAL FORM**

(PRINT) FIRST NAME		MIDDLE NAME		LAST NAME	
RESIDENCE ADDRESS			MAILING ADDRESS		
STREET:			ADDRESS:		
CITY:		ZIP:	CITY:		ZIP:
BIRTH DATE		SOCIAL SECURITY NUMBER		EMAIL ADDR.:	
____/____/____		____-____-____		PHONE #:	
SEX	BLOOD TYPE	ORGAN DONOR		GLASSES	
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
HEIGHT	WEIGHT	EYE COLOR:		PLACE OF BIRTH	
____ FT ____ IN	____ LBS	____		____	
		HAIR COLOR:			
		____			
<b>MILITARY DRAFT REGISTRATION</b>					
<small>"BY SUBMITTING THIS APPLICATION, I AM CONSENTING TO REGISTRATION WITH THE SELECTIVE SERVICE SYSTEM, IF SO REQUIRED BY FEDERAL LAW. IF UNDER (18) YEARS OF AGE, I UNDERSTAND THAT I WILL BE REGISTERED AS REQUIRED BY FEDERAL LAW WHEN I ATTAIN EIGHTEEN (18) YEARS OF AGE."</small>					
<b>WARNING</b>					
<small>UNDER TITLE 20, SECTION 548 VIC, IT IS IN VIOLATION "TO USE FALSE OR FICTITIOUS NAMES IN ANY APPLICATION FOR A DRIVER'S LICENSE OR IDENTIFICATION CARD, OR KNOWINGLY TO MAKE A FALSE STATEMENT, KNOWINGLY CONCEAL A MATERIAL FACT OR OTHERWISE COMMIT A FRAUD IN ANY SUCH APPLICATION."</small>					
----- Signature			----- Date		

No appointment will be given by phone. Cancellation must be made within 48 hours prior to the test date by phone or in person. If test is not canceled, payment will be required for a new appointment.  
Please bring your own vehicle (NO RENTAL) proceed to the BMV with a driver who has a valid V.I. Driver's License. Emergency brake must be in the center of the vehicle.

**TO CANCEL CALL 340-713-4268 WITHIN 48 HOURS**

**For BMV Office Use ONLY.**

	Receipt Number	Appointment Date	Time	Authorized	Date
Written Test / Road Test					
Written Test / Road Test					
Written Test / Road Test					
Written Test / Road Test					





POLICE DEPARTMENT

MEDICAL EXAMINATION



**INFORMATION TO BE FILLED OUT AND SIGNED BY A LICENSED PHYSICIAN**

DOES THE APPLICANT SUFFER FROM: Epilepsy?  Excessively high blood pressure?  Diabetic?   
 Bright's disease?  Fainting spells?  Any heart ailment?  Is the applicant crippled in any manner?   
 Is his hearing defective?  Has he any mental illness?  Been confined to any hospital, public or private institution  
 for mental illness?  Suffered any physical disability?  Suffered a physical deformity or the loss of leg, arm, hand  
 or foot?  Suffered a stroke?  Active rheumatic fever?  Hypertension with complications?

CONCLUSION: I am of the opinion that the referred to applicant has met the physical requirements for a driver's li-  
 cense for private vehicle ; public vehicle ; commercial vehicle ; neither .

\_\_\_\_\_  
SIGNATURE OF MEDICAL EXAMINER

VISUAL EXAMINATION

V R.E. 20/ (Without glasses)  
 L.E. 20/ (Without glasses)

V R.E. 20/ (With glasses)  
 L.E. 20/ (With glasses)

Visual Field in Horizontal Meridian:

V R.E.: degrees  
 L.E.: degrees

**NOTES:**

The following are recommendations for the minimal visual standards for public transportation and/or operators:

- A. A correctable visual acuity to 20/30 Snellen in each eye. If corrective glasses are required for obtain-  
 ing visual acuity of 20/30, unbreakable glasses or an extra pair of glasses should be mandatory.
- B. Form fields of 70 degrees in the horizontal meridian with each eye and 140 degrees in the horizontal  
 meridian with both eyes.

The following are recommended as the minimal requirements for private car operators:

- A. A correctable visual acuity to 20/40 Snellen in one (the better) eye.
- B. Form fields of 70 degrees in the horizontal meridian in each eye and 140 degrees in the horizontal me-  
 ridian eye.
- C. Re-examination of eyes every three years.

CONCLUSION: I am of the opinion that the referred to applicant has met the physical requirements for a driv-  
 er's license for private vehicle  public vehicle; ; commercial vehicle ; neither

TO APPLICANT:

Private License   
 Public License   
 Commercial License

*(Please indicate type of License desired)*

\_\_\_\_\_  
SIGNATURE OF MEDICAL EXAMINER