COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES
DRIVER'S LICENSE SECTION

Caller Box 10007 Saipan, MP 96950
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PLEASE CHECK

☐ NEW PERMIT
☐ RENEWAL
☐ DUPLICATE

COMMONWEALTH OF THE NORTHERN MARIANAS GOVERNMENT MOTOR VEHICLES OPERATOR'S IDENTIFICATION CARD.

This form must be completed before any person may be issued a Commonwealth of the Northern Marianas Government Motors Operator's Identification Card SF-46, either as a regular operator or an Incidental Operator.

Check One: ☐ Operator ☐ Incidental Operator Sex: ☐ Female ☐ Male U.S. Citizen ☐

Applicant's Name: _____ Title: _____

Date of Birth: _____ Place of Birth _____ Color of eyes: _____

Color of hair: _____ Height : _____ Weight _____ Social Security: _____

Type(s) of vehicle to Operate _____ Department: _____ Tel: _____

Part Two: SUMMARY OF DRIVING (Include Privately-Owned Vehicles)

1. No yr. of Driving
2. Type of vehicle Operated No. Yrs.
3. CNMI Pvt. Drivers License Number Issued/Expired

4. Records of Arrest or Summons (Except parking) If renewal enter past 3 years.
   Date: Nature of Type of Violation: City and State: Action Taken:

5. Records of Accidents for five years. (If renewal enter past 3 years only)
   Date: Nature of Type of Violation: City and State: Action Taken:

6. Records of Safe Driving Awards. (Do not include auto insurance cards).
   If renewal enter past 3 years only. Date: Type of Awards:

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

APPLICANT'S SIGNATURE: _____ DATE _____

PHYSICAL FITNESS INQUIRY FOR MOTOR VEHICLE OPERATORS

Last Name	First Name	Middle Name	Date of Birth	Position Title

Home address (Number, street or RFD, city or town, state, zip code)	Department

Have you ever had or have you now (please check at left of each item)

☐	☐	Poor vision in one or both eyes	☐	☐	Arthritis, rheumatism, swollen or
☐	☐	Eye disease	☐	☐	painful joints
☐	☐	Poor hearing in one or both ears	☐	☐	Loss of hand, arm, foot, or leg
☐	☐	Diabetes	☐	☐	Deformity of hand, arm foot, or leg
☐	☐	Palpitation, chest pain or shortness	☐	☐	Nervous of mental trouble of any kind
☐	☐	of breath	☐	☐	Blackouts or epilepsy
☐	☐	Dizziness or fainting spells	☐	☐	Sugar or albumin in urine
☐	☐	Frequent or severe headaches	☐	☐	Excessive drinking habit (Alcohol)
☐	☐	High or low blood pressure	☐	☐	Other serious defects or diseases
☐	☐	Drug or narcotic habit	☐	☐	

If your answer is "Yes" to one or more of the above question. Explain fully in this space.

(A) Do you wear glasses? Yes ☐ No ☐ (B) Do you wear contact lenses? Yes ☐ No ☐

(C) Do you wear a hearing aid? Yes ☐ No ☐

I certify that my answers above are full and true, and I understand a false statement or dishonest answer to any question may be grounds for cancellation of my eligibility or my dismissal from the service and is punishable by law.

Signature Date

Review and certification by designated official

I certify that I have reviewed this physical fitness inquiry form and other available information regarding the physical condition of the applicant, and this I have made the following determination:

☐ There is no information on this form or otherwise available to indicate that the applicant should be reffered for physical examination.

☐ On the basis of items checked on this form or other information, this applicant must be reffered for physical examination before he is authorized to operate a Government-owned motor vehicle or his current authorization is renewed.

☐ Items checked on this form or otherwise available do not warrant refferal for medical examination because of the following facts:

Commissioner of Public Safety or Designee Date: _____