

1. Have at least three years of being abstinent from all alcoholic beverages, illegal drugs, or misuse of prescription-regulated drugs. Even some beers and wines labeled “non-alcoholic” contain alcohol and may not be consumed under Total Abstinence. Marijuana is considered a non-prescribed regulated drug. Whether you are licensed with the Vermont Medical Marijuana Registry or not, the use of marijuana is a disqualifying substance and is prohibited in the Total Abstinence Program.
2. Applicants must have installed and utilized an ignition interlock system in their vehicle for three full years prior to application to the Total Abstinence Program.
3. Complete an Impaired Driver Rehabilitation Program (IDRP) intake at one of the IDRP sites to discuss your intentions to prove Total Abstinence with your IDRP Evaluator.
4. Complete treatment consisting of a minimum of 20 hours over a minimum of 24 weeks with a Licensed Alcohol and Drug Counselor (LADC). The counselor, IDRP Evaluator, and a representative from IDRP will determine when you have successfully completed treatment.
5. Complete the Total Abstinence Packet (form VS-077). The entire packet, once completed, should be mailed to -

**Enforcement & Safety Division
Vermont DMV
120 State Street
Montpelier, Vermont 05603**

6. Your counselor must submit a **Treatment Information** form to the IDRP Evaluator stating that you have successfully completed your therapy program. You will need to contact your IDRP Evaluator to schedule an **exit interview**.
7. **Application fee of \$500.00**
 - Check made payable to the Vermont Department of Motor Vehicles
 - Credit Card payments will be accepted over the phone.
 - **Credit Card payment will not be accepted before the packet is received.** It is the responsibility of the applicant to contact the Vermont Department of Motor Vehicle Enforcement and Safety Division at 802.828.2067 **after the Department has received your completed Total Abstinence Packet.**



DEPARTMENT OF MOTOR VEHICLES
Agency of Transportation

dmv.vermont.gov

120 State Street
Montpelier, Vermont 05603-0001
802.828.2000
Toll Free: 888-99-VERMONT
TTD: 711

**ABSTINENCE FROM ALCOHOL AND DRUGS
MEDICAL & INFORMATION AUTHORIZATION TO DISCLOSE FORM**

_____, Date of Birth: _____

Applicant Name (type or print clearly)

Applicant Address: _____
Number Street apt. # Town/City State ZIP

Applicant Phone: _____

I authorize the following institution(s) to disclose/release Information:

To Send Information by mail to:
**Enforcement & Safety Division
Vermont Department of Motor Vehicles
120 State Street
Montpelier, Vermont 05603-0001**

Or Fax to: **802-828-2092**

The type of information requested is signified by the boxes checked below:

- All prescriptions including date prescribed, quantity, Mg dosage, prescribing physician name and label directions from _____ to _____.
Date Date
- Any and all medical records, doctor notes, counseling records and other information regarding use of alcohol, marijuana, illegal drugs or abuse of prescribed medications from _____ to _____.
Date Date
- Any and all laboratory results showing alcohol and/or drug levels from _____ to _____.
Date Date
- Provide a letter from primary doctor, and or their designee, providing medical opinion on applicant's ability to safely operate a motor vehicle on a public highway after a review of the applicant's current medical condition, medical history and consideration to currently prescribed medications.
- Any referrals made to counseling services or other medical professionals

ABSTINENCE FROM ALCOHOL AND DRUGS
MEDICAL & INFORMATION AUTHORIZATION TO DISCLOSE FORM

Other:

I understand my records are protected under the Federal Confidentiality Regulations (*42 CFR Part - 2*), published July 1, 1975 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I may revoke this consent at any time except to the extent action has been taken in reliance to it, (*i.e. - Probation, Parole, etc.*) and in any event, this consent expires automatically as described below.

I understand in the event of bill collection through Vermont District Court, confidentiality cannot be guaranteed.

I understand this waiver is valid for a period of one year from the date of my signature below.

I hereby affirm, under penalty of perjury of the laws of the State of Vermont, that the information on this form is true and correct. This declaration made under penalties of 23 V.S.A. § 202 & § 4110.

(Applicant Signature)

(Date)

(Witness Signature)

(Date)



**CORRECTIONS AND/OR PROBATION INFORMATION FORM
ABSTINENCE FROM ALCOHOL AND DRUGS**

(TO BE FILLED OUT BY THE INDIVIDUAL SUPERVISING THE APPLICANT)

The individual that is supplying you with this form is trying to obtain the reinstatement of their privilege to drive by proving Total Abstinence from alcohol, illegal drugs and/or taking a regulated prescription drug(s) not consistent with the prescription label. As part of the Total Abstinence process, The Impaired Driver Rehabilitation Program and the Vermont Department of Motor Vehicles will need information about any incarcerations, and levels of supervision given to the individual while on probation or while serving any sanctions for the Department of Corrections. Per 23 VSA 1209(b)(1), the period of abstinence shall not include serving a sentence of incarceration to include furlough.

Date this form was submitted to Corrections/Probation: _____

If this form is being filled out in the State of Vermont, please return the form to your local Impaired Driver Rehabilitation Project Evaluator. If the form is being filled out in a State other than Vermont, please return this form to: Impaired Driver Rehabilitation Program, 108 Cherry Street, PO Box 70, Burlington, VT 05402-0070. If you have questions, please contact the Impaired Driver Rehabilitation Program as 802-651-1574.

Please write clearly or type

Applicant's Name: _____ Applicant's Date of Birth: _____

Has this applicant been on *any type* of Custody and/or Probation: _____ **Yes** _____ **No**

(If no, please sign and date this form and return it to the Impaired Driver Rehabilitation Program Evaluator, or The Impaired Driver Rehabilitation Program. If **yes**, please continue.)

When proving Total Abstinence, the level of supervision given to an individual is essential. Please provide below, the information you have relative to date(s) and types of supervision, along with information regarding alcohol and or drug use that applicant may have had.

Has this person been on supervision with the Department of Corrections within the past three years?

YES _____ **NO** _____

If **yes**, please document the applicable manners of supervision:

Incarceration dates _____ to _____

Work Crew dates _____ to _____

Supervised Community Sentence dates _____ to _____

Furlough dates (Any kind) _____ to _____



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Probation dates _____ to _____

Parole dates _____ to _____

Are there any indications of alcohol or illegal drug use(s) **YES** _____ **NO** _____

If **yes**, please complete the following and indicate BAC results and or type(s) of drugs discovered:

Date Type of substance (If alcohol list BAC results) Discovered how (Observation, test, other)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date this individual was released from all supervision: _____

Information of Individuals Supervising the applicant:

Employee Name: _____ Employee Phone: _____

Employee Job Status (Retired, Transferred, Etc.): _____

Location/Address of Office _____

Dates employee supervised applicant: _____ to _____

Employee Name: _____ Employee Phone: _____

Employee Job Status (Retired, Transferred, Etc.): _____

Location/Address of Office _____

Dates employee supervised applicant: _____ to _____



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DEPARTMENT OF MOTOR VEHICLES
Agency of Transportation

120 State Street
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Employee Name: _____ Employee Phone: _____

Employee Job Status (Retired, Transferred, Etc.): _____

Location/Address of Office _____

Dates employee supervised applicant: _____ to _____

Comments and or other pertinent information for the investigator conducting the applicant's background investigation:

Name of Individual filling out form Date

Title

To Corrections:

Please return this completed form to the Enforcement & Safety Division of the Vermont Department of Motor Vehicles by scanning and attaching it to an email. Please indicate in the subject field of the email "Total Abstinence." The email address to forward it to is:

DMV-Enforcement@vermont.gov

In the event you need to send the completed form by U.S. Mail, please mail to:

Enforcement & Safety Division
Vermont Department of Motor Vehicles
120 State Street
Montpelier, Vermont 05603

**REFERENCE & ACQUAINTANCE CONTACT FORM
ABSTINENCE FROM ALCOHOL AND DRUGS**

The individual that is supplying you with this form is trying to gain reinstatement of their privilege to drive in the State of Vermont by proving Total Abstinence from alcohol, illegal drugs and/or taking a regulated prescription drug(s) not consistent with the prescription label. Reinstatement of the Applicant's license will be based, in part, on the information you provide.

The individual filling out this form must have known the applicant during his or her term of abstinence (3 years) and has had personal contact with the applicant. Please be sure that the information you provide is as clear and complete as possible. This document must be signed in the presence of a Notary Public. Generally, Notary Publics are available at Town Clerk offices, banks, and legal offices. **PLEASE WRITE CLEARLY OR TYPE**

Applicant's Name: _____

Your Name: _____ Your Date of Birth: _____

Your Physical Address: _____

Your E-Mail Address: _____

Your Telephone Number: Home (____) _____ Work: (____) _____ Cell (____) _____

Your Relationship to Applicant: _____

How long have you known the Applicant: _____

How often do you have contact with the Applicant: _____

What's the last date you saw the applicant: _____

When is the approximate last time you personally were aware the applicant was consuming alcohol, marijuana, using illegal drugs or taking a regulated prescription drug(s) not consistent with the prescription label?

I hereby affirm, under penalty of perjury of the laws of the State of Vermont, that the information on this form is true and correct. This declaration made under penalties of 23 V.S.A. § 202 & § 4110.

Affiant - Print Name_____
Affiant – Signature

Subscribed and sworn to before me on _____, at _____, Vermont

Date Town

Notary – Print name_____
Notary Phone Number_____
Notary – Signature (Expires 02/10/20____)

Total Abstinence Applicant Personal History Questionnaire**Section A. Applicant Identification:** Information provided is for identification and contact purposes.Name: _____
(Last) (First) (Middle Initial)Date of Birth: _____ Place of Birth _____
(City) (State) (Zip Code)Physical Address: _____
(Number) (Street) (Apt. #) (City) (State) (Zip)

Mailing Address: (if different from above):

(Number) (Street) (Apt. #) (City) (State) (Zip)Phone Numbers: _____
(Home) (Work) (Cell)

E-Mail Address: _____

Nickname(s), maiden name, or other name(s) by which you have been known:

Do you currently operate a motor vehicle that has a device, which requires you to provide a breath sample in order to start the vehicle (Interlock Safety Device)?

(Please circle): **YES** **NO**

Name of Interlock Device Vendor: _____

Date Installed: _____ Vehicle: _____
(Year) (Make) (Model) (Registration #)

Name of Previous Vendor(s) (if applicable): _____

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Section B. Residences: List all addresses where you have lived during your time of abstinence, beginning with present address. List dates by month and year. (Attach extra page if necessary).

1. From _____ to Present

(Number) (Street) (Apt. #) (City) (State) (Zip)

2. From _____ to _____

(Number) (Street) (Apt. #) (City) (State) (Zip)

3. From _____ to _____

(Number) (Street) (Apt. #) (City) (State) (Zip)

4. From _____ to _____

(Number) (Street) (Apt. #) (City) (State) (Zip)

Section C. Employment: Beginning with your present or most recent job, list all employment during your time of abstinence. Include periods of unemployment. Attach extra sheet if necessary.

1. Employer: _____ Phone: _____

Address: _____
(Number) (Street) (City) (State) (Zip)

Dates: _____ Supervisor(s): _____

2. Employer: _____ Phone: _____

Address: _____
(Number) (Street) (City) (State) (Zip)

Dates: _____ Supervisor(s): _____

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3. Employer: _____ Phone: _____

Address: _____
(Number) (Street) (City) (State) (Zip)

Dates: _____ Supervisor(s): _____

4. Employer: _____ Phone: _____

Address: _____
(Number) (Street) (City) (State) (Zip)

Dates: _____ Supervisor(s): _____

Section D. Relatives:1. Relationship Status (Circle): Single Partner Married Separated Divorced Widowed

2. Current Relationship's Name: _____ DOB: _____

Address: _____
(Number) (Street) (City) (State) (Zip)Phone(s): _____
(Home) (Work) (Cell)

E-Mail Address: _____

3. Ex-Relationship's Name: _____ DOB _____

Address: _____
(Number) (Street) (City) (State) (Zip)Phone(s): _____
(Home) (Work) (Cell)

E-Mail Address: _____

4. Other Relatives: List all children, parents, and siblings. Use extra sheet if necessary.

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Phone(s): _____ Phone(s): _____

E-Mail: _____ E-Mail: _____



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TTD: 711

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Address: _____ Address: _____
Phone(s): _____ Phone(s): _____
E-Mail: _____ E-Mail: _____

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Address: _____ Address: _____
Phone(s): _____ Phone(s): _____
E-Mail: _____ E-Mail: _____

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Address: _____ Address: _____
Phone(s): _____ Phone(s): _____
E-Mail: _____ E-Mail: _____

Name: _____ Name: _____
Relationship: _____ Relationship: _____
Address: _____ Address: _____
Phone(s): _____ Phone(s): _____
E-Mail: _____ E-Mail: _____

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Section G. Prior Drinking Preferences: List your preferred type of alcoholic beverage(s) from when you were still consuming alcohol (i.e. – wine, wine coolers, light beer, vodka). Be sure to be specific as to brand name(s) (i.e. – Budweiser, Captain Morgan) and where you purchased alcohol from (i.e.- Hannaford, Cumberland Farms, VFW, etc.)

Preferred type of alcohol: _____

List specific brand(s): _____

Where purchased: _____

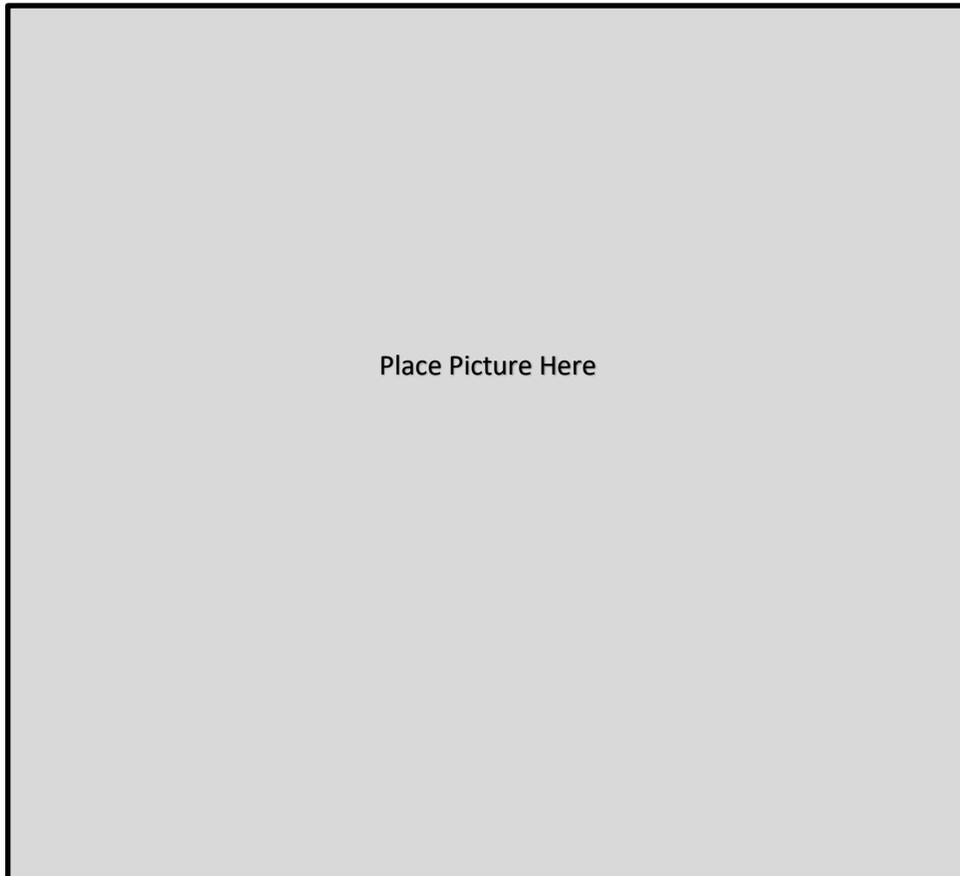
Section H. Declaration: This document must be signed by the applicant in the presence of a Notary Public. Generally, Notary Publics are available at Town Clerk offices, banks, and legal offices.

I hereby affirm, under penalty of perjury of the laws of the State of Vermont, that the information on this form is true and correct. This declaration made under penalties of 23 V.S.A. § 202 & § 4110.

Affiant - Print Name_____
Affiant – SignatureSubscribed and sworn to before me on _____, at _____, Vermont
Date Town_____
Notary – Print name_____
Notary Phone Number_____
Notary – Signature (Expires 02/10/20____)

Section I. (Photograph): Note: This photograph will not be returned to you. If a current photograph is not attached, your application for abstinence will be rejected.

Attach an Up-To-Date Photograph in the shaded area below (Head & Shoulders)





Applicant's Sworn Declaration Abstinence from Alcohol and Drugs

Department of Motor Vehicles
Agency of Transportation
dmv.vermont.gov

120 State Street
Montpelier, Vermont 05603-0001

This form is required if an individual is proving total abstinence to try to obtain the privilege of driving back in Vermont. Note: If Any Questions are Unanswered, the Form Will be Returned. Please write clearly or type

Mail the completed form to
RDL Unit
Vermont Department of Motor Vehicles
120 State Street
Montpelier, Vermont 05603
Phone: 802.828.2000
Email: dmv.vermont.gov/contact

Impaired Driver Rehabilitation Program (IDRP)
Vermont Department of Health
108 Cherry Street
Burlington, VT 05401
Phone: 802.651.1574
Fax: 866.272.7989
Email: AHS.VDHIDRP@vermont.gov

Full Name: Date of Birth:

Current Mailing Address:

Physical Address (Add directions if in a Rural Area)

Telephone: Home () Work () Cell ()

E-Mail Address

Employers Name, Address and Phone #

Work Schedule (Include days & hours worked)

Please indicate whether you were ever on Probation: Yes No (If you were ever on Probation, you will need to have a Corrections and/or Probation Information form filled out by your Probation Office. A form may be obtained from the Impaired Driver Rehabilitation Program Evaluator. If you live in a State other than Vermont, please contact the Impaired Driver Rehabilitation Program at 802-651-1574)

If yes, please give the name of your Probation Officer:

Location of Probation Office:

Probation Officer's telephone Number:

In your own words, describe the conditions, behaviors, changes, etc. in your life which are associated with your abstinence. Include any other statements that you wish to make at this time. (Use / attach additional paper if needed.)

Multiple horizontal lines for writing a personal statement.

Department of Motor Vehicles
Agency of Transportation
dmv.vermont.gov

120 State Street
Montpelier, Vermont 05603-0001

Instructions to the applicant: Please read the following and sign the sworn declaration. This document must be signed in the presence of a Notary Public. Generally, Notary Publics are available at Town Clerk offices, banks, and legal offices.

I am applying for license reinstatement through the State of Vermont's Total Abstinence Program. Whether or not I am licensed with the Vermont Medical Marijuana Registry, I understand that marijuana is a non-prescribed regulated drug. I understand if it has been determined through the Total Abstinence Investigation, my privilege to operate is reinstated, I can never consume alcohol, Marijuana, use illegal drugs or use a regulated prescription drug, as defined in 18 VSA §4201(29), in a manner that is inconsistent with the prescription label, again. This includes my time of abstinence, including the subsequent investigation period. I understand any amount of the above-described substances, used in the manner described above, if reinstated, is grounds for the immediate and permanent revocation of my operator's license and I can never apply for total abstinence again. I understand this rule applies to any situation where I might consume any of the above-described substances, in the manner described above, and I understand there is no requirement for me to be operating a motor vehicle.

I further understand I may be asked to submit to a urinalysis drug and alcohol screening during my total abstinence investigation by an agent of the Department of Motor Vehicles or other law enforcement entities. I understand my refusal to submit is grounds for immediate termination of my investigation and I will be denied license reinstatement. I acknowledge that a positive result for any of the aforementioned is grounds for immediate termination of my investigation.

By applying for license reinstatement through the Total Abstinence Program, I fully agree with the rules outlined above. I swear I have been totally abstinent from any alcohol, illegal drug use and/or have not taken any regulated prescription drug inconsistent with the prescription label as of:

_____, which is _____ years and _____ months.
(Date Abstinence Began)

I hereby affirm, under penalty of perjury of the laws of the State of Vermont, that the information on this form is true and correct. This declaration made under penalties of 23 V.S.A. § 202 & § 4110.

Affiant - Print Name

Affiant – Signature

Subscribed and sworn to before me on _____, at _____, Vermont
Date Town

Notary – Print name

Notary Phone Number

Notary – Signature Expires 02/10/20____)



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**LETTER OF SUPPORT STATEMENT
ABSTINENCE FROM ALCOHOL AND DRUGS**

The individual/applicant that is supplying you with this form is trying to reinstate their privilege to drive in the State of Vermont by proving Total Abstinence from alcohol, illegal drugs and/or taking a regulated prescription drug(s) not consistent with the prescription label. Reinstatement of the Applicant's license will be based, in part, on the information you provide.

The individual filling out this form must have known the applicant during his or her term of abstinence (3 years) and has had ongoing personal contact with the applicant during the term. Please be sure that the information you provide is as clear and complete as possible. This document must be signed in the presence of a Notary Public. Generally, Notary Publics are available at Town Clerk offices, banks, and legal offices.

PLEASE WRITE CLEARLY OR TYPE

Applicant's Name: _____

Your Name: _____ Your Date of Birth: _____

Your Physical Address: _____

Your Email Address: _____

Your Phone Number: Home (____) _____ Work: (____) _____ Cell (____) _____

Your Relationship to Applicant: _____

How Long Have You Known the Applicant: _____

How Often Do You Have Contact with the Applicant: _____

To the best of your knowledge, how long has the Applicant been abstinent from alcohol, marijuana, illegal drug use or from taking a regulated prescription drug inconsistent with the prescription label?

In your own words, describe the conditions, behaviors, changes, etc. which cause you to believe that the Applicant has been abstinent for that period of time.

OVER

