

RESTRICTED LICENSE WORKSHEET
FILL OUT COMPLETELY AND PRINT LEGIBLY

****All requests must listed be on this worksheet, or they will not be granted****

FULL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

VIRGINIA LICENSE # OR SOCIAL SECURITY #: _____

RACE: ___ SEX: ___ DOB: _____ HEIGHT: ___' ___" WEIGHT: _____ EYES: ___ HAIR: ___

EMPLOYER NAME & COMPLETE ADDRESS: _____

ADDRESS WHERE YOU REPORT TO WORK IF DIFFERENT THAN ABOVE: _____

2ND EMPLOYER (if applicable, NAME & ADDRESS: _____

EXACT HOURS YOU REPORT TO WORK & LEAVE WORK. MAXIMUM AMOUNT OF TIME ALLOWED IS 6 DAYS PER WEEK & 12 HOURS PER DAY.

****DO NOT INCLUDE TRAVEL TIME.**

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
TO	TO	TO	TO	TO	TO	TO

DO YOU NEED TO DRIVE AS PART OF YOUR EMPLOYMENT? YES _____ NO _____

LENGTH OF TIME IT TAKES TO TRAVEL TO WORK ONE-WAY: _____

IF GRANTED, SCHOOL NAME, ADDRESS & SCHEDULE: _____

IF GRANTED, MEDICAL TRAVEL (GIVE DETAILS): SELF: _____ CHILD: _____
DOCTOR'S NAME & COMPLETE ADDRESS: _____

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IF GRANTED, TRAVEL NECESSARY TO TRANSPORT CHILD TO & FROM DAY SCHOOL (SCHOOL NAME & ADDRESS, DROP OFF & PICK UP TIMES): _____

IF GRANTED, TRAVEL NECESSARY TO TRANSPORT CHILD TO & FROM DAY CARE (DAYCARE NAME & ADDRESS, DROP OFF & PICK UP TIMES): _____

IF GRANTED, TRAVEL NECESSARY TO TRANSPORT CHILD TO & FROM MEDICAL FACILITY (GIVE MEDICAL PROVIDERS NAME & ADDRESS): _____

IF GRANTED, RELIGIOUS SERVICE (NAME OF FACILITY; ADDRESS; DAY & TIME OF SERVICE): _____

ARE YOU ON PROBATION? _____ YES _____ NO

NAME OF PROBATION OFFICER: _____

ADDRESS OF LOCATION YOU REPORT TO: _____

ANY ADDITIONAL REQUESTS FOR TRAVEL NOT LISTED ON THIS FORM: _____
