

**INSTRUCTIONS FOR APPLYING FOR DRIVING PRIVILEGES FOR DRIVING  
SUSPENSIONS ISSUED BY THE BUREAU OF MOTOR VEHICLES**

To apply for driving privileges, you must complete the following steps. Failure to do so may result in your application being denied.

1. Submit a completed motion for driving privileges to the **Clerk of Court Civil Division**. A standard form is available from the Clerk of Court or may be obtained from the Wayne County Municipal Court website ([waynemunicipalcourt.org](http://waynemunicipalcourt.org)). **You must include the address, date and time (if applicable) of each request. You must include your home address, mailing address if different, your social security number and a phone number to reach you at.**
2. Include with your motion a copy of your current proof of insurance, with your name listed, or an SR22 bond.
3. Complete and submit the Confidential Medical Information Form, if you are requesting medical privileges.
4. Submit the **\$130.00 filing fee**.

Once your request is ruled upon by the Court you must obtain a driving letter from the Court Secretary prior to privileges being effective.

The Court and Clerk of Court cannot provide legal advice. If you have questions or require further assistance, please contact legal counsel.

IN THE WAYNE COUNTY MUNICIPAL COURT

WOOSTER, OHIO

\_\_\_\_\_ : Case No. \_\_\_\_\_  
Appellant :  
 : MOTION FOR DRIVING PRIVILEGES  
vs. :  
 :  
 :  
BUREAU OF MOTOR VEHICLES :  
Appellee :

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This matter comes before the Court upon the motion of the Appellant for driving privileges. The driving privileges being requested are for the following purposes:

**WILL YOU NEED PLACED ON A COURT MONITOR PAYMENT PLAN FOR YOUR OUTSTANDING REINSTATEMENT FEES OWED TO THE BMV:**

**(CIRCLE ONE) YES / NO**

**Occupational purposes:**

1. Place of Employment \_\_\_\_\_
2. Name of Direct Supervisor \_\_\_\_\_
3. Supervisor's phone \_\_\_\_\_
4. Location(s)/ Address(s) of work \_\_\_\_\_  
\_\_\_\_\_
5. Days and Hours of Work: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Educational purposes:**

1. Name, location/address of School \_\_\_\_\_  
\_\_\_\_\_
2. Days and Hours of School: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical purposes:** Attach the confidential medical information sheet.

**Other requested purposes (submit- addresses, dates and times if applicable):**

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**Appellant's Name (printed)**

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**Appellant's Address**

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**Appellant's Phone Number**

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**Appellant's Social Security Number**

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\_\_\_\_\_  
**Appellant's signature**

# CONFIDENTIAL MEDICAL INFORMATION

The information submitted on this form is confidential and will not be available for public inspection. Upon request, the State of Ohio will be permitted to view this form.

Name of **Appellant** \_\_\_\_\_ Case No. \_\_\_\_\_

1. Name and address of Medical Provider \_\_\_\_\_

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Location of services, if different than above \_\_\_\_\_

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2. Name and address of Medical Provider \_\_\_\_\_

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Location of services, if different than above \_\_\_\_\_

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3. Name and address of Medical Provider \_\_\_\_\_

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Location of services, if different than above \_\_\_\_\_

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4. Name and address of Medical Provider \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location of services, if different than above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Name and address of Medical Provider \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location of services, if different than above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Name and address of Medical Provider \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location of services, if different than above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_