REGISTRY OF MOTOR VEHICLES

One Year Photo Extension Application

Save time, go to mass.gov/RMV to apply online!

An applicant for a driver's license or ID card renewal who needs a new photograph can be given a one-year extension of the use of the current photograph. A licensed physician must certify that the applicant's appearance has temporarily been changed due to medical treatment. The fee for this transaction is $10 for a license and $5 for an ID card. The new driver's license or ID card will be valid for one year. The applicant will need to renew the driver's license or ID card when in one year (at the normal fee) with a new photograph. This extension cannot be given for longer than one consecutive year unless an exception is made by the Registrar or their designee.

Instructions: Present this completed application, along with a completed Class D, M, or D/M License and ID Card Application or a completed CDL Application to an RMV Service Center. Visit mass.gov/id to review the requirements and complete your renewal application online.

A. Applicant Information

Last Name	First Name	Middle Name	Suffix

Date of Birth (MM/DD/YYYY)	Driver's License #	

Address

Street Apt. # City State Zip Code

Applicant Signature and Certification (Required)

I certify under the pains and penalties of perjury that all the information provided in this application, including the representation of my medical status/condition, is true and correct to the best of my knowledge.

Applicant Signature:_____ Date: _____

B. Healthcare Provider Information

In my professional opinion and to a reasonable degree of medical certainty, this patient has undergone and/or is undergoing medical treatment for an illness which has resulted in temporary changes to the physical characteristics of the applicant that would be apparent in an image captured by the Registry of Motor Vehicles.

Healthcare Provider Last Name	First Name	Middle Name	Suffix

Address

Street City State Zip Code

Daytime Phone #	Board of Registration in Medicine #	

Healthcare Provider Signature and Certification (Required)

I certify that I am a licensed physician and certify under the pains and penalty of perjury that the information I have provided is true and correct.

Healthcare Provider Signature: _____ Date: _____