

COMMONWEALTH OF MASSACHUSETTS
REGISTRY OF MOTOR VEHICLES
P.O. Box 55889
Boston, MA 02205-5889

REQUEST FOR DRIVING RECORD
(Fee: \$15.00)

(PLEASE PRINT CLEARLY)

DATE:

NAME OF REQUESTOR:

ADDRESS OF REQUESTOR:
as an authorized representative of:

Name of Company/Agency

Company/Agency Address

requests a Driving Record for the following person:

(All Information MUST be supplied)*

DRIVERS= NAME:

(Last)

(First)

(Middle Name
or Initial)

DRIVER'S DATE OF BIRTH:

____ / ____ / ____
month day year

DRIVER'S LICENSE NO:

*If you do not know the Driver's License Number and believe that you may qualify as a permitted user of personal information from motor vehicle records under the Driver Privacy Protection Act, 18 U.S.C. §2721 et seq. Please indicate this to the RMV representative.

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