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 $25. 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 can only be given one time.

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. **Effective 3/26/18, you need documentation showing United States citizenship or lawful presence as required by federal and state law to renew your driver's license. Visit mass.gov/id to review these 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. Licensed Physician 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.

Licensed Physician Last Name	First Name	Middle Name	Suffix

Address

Street City State Zip Code

Daytime Phone #	Board of Registration in Medicine #	

Licensed Physician 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.

Licensed Physician Signature: _____ Date: _____