Click here to START or CLEAR, then hit the TAB button

WASHINGTON STATE DEPARTMENT OF LICENSING

CDL School/Employer Student Skills Testing Schedule

SUBMIT

School/Employer name	Tests for week of:	Type ☐ DOL ☐ TPE	Date submitted
Contact name	Contact email address		Phone number

DL Number	Last name	First name	DOB	Customer Phone #	CDL Class	Test Type	Vehicle Type	Endorse-ments	Brakes	Trans.	Preferred Test Dates/ Comments	Certificate Submitted
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