

DARKE COUNTY MUNICIPAL COURT
504 SOUTH BROADWAY, SUITE 7
GREENVILLE, OHIO 45331

Name: _____

Case No.: _____

Address: _____

City, State Zip: _____

PLAINTIFF,

VS

JUDGE JULIE L. MONNIN

Charles L. Norman
Bureau of Motor Vehicles
P.O. Box 16520
Columbus, OH 45316

**COMPLAINT FOR CIVIL
DRIVING PRIVILEGES**

DEFENDANT.

1. Plaintiff states that they received a letter from the BMV suspending their driver's license. A copy of the letter **MUST** be attached to this Complaint when filed.
2. Plaintiff requests limited driving privileges.
3. Plaintiff agrees to pay court costs of \$103.00 at the time of filing.

State of Ohio, Darke County, ss:

I, being duly sworn, say that I am the Plaintiff in this matter and that the facts stated in this complaint and application are true.

Signature of Plaintiff

Sworn to and signed in my presence on _____.

Clerk / Deputy Clerk

APPLICATION FOR CIVIL DRIVING PRIVILEGES

Full Name: _____ DL #: _____
(Driver's License Number)

Phone Number: _____ SSN: _____

Email Address: _____ DOB: _____

Copy of SR22 Insurance attached Copy of BMV suspension letter attached

1. Primary Employment:

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Attached is proof from employer on company letterhead (signed by employer) with days & hours worked, if the employee is required to drive during work hours **AND** if overtime is mandatory or volunteer based.

2. Secondary Employment:

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Attached is proof from employer on company letterhead (signed by employer) with days & hours worked, if the employee is required to drive during work hours **AND** if overtime is mandatory or volunteer based.

3. Education & Vocational Purposes:

School Name: _____

School Address: _____

School Phone Number: _____

Attached is proof from school of days and hours of classes

4. Medical and/or Treatment Programs (including AA, MADD, Counseling, IOP, Aftercare):

Medical: _____

Outpatient Treatment: _____

Aftercare: _____

AA/MADD: _____

Counseling: _____

Other: _____

Attached is proof from Medical Professional and/or Treatment agency of days & hours of treatment

5. Does another licensed driver live in your home? Yes No

If no, circle the day of the week and write a 3-hour timeframe below for personal errands

Mon – Tues – Wed – Thurs – Fri – Sat – Sun Timeframe: _____

6. Other:

Name: _____

Address: _____

Phone Number: _____

Please explain: _____

