



UNITED STATES OF AMERICA REPUBLIC

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Can send in by Fax or Email, for quicker results but HARD COPY IS NEEDED FOR ORIGINAL FILING also make copy for self.

Thank you for your interest in Applying for your UNITED STATES OF AMERICA REPUBLIC driver's license, permit, or ID card. The UNITED STATES OF AMERICA REPUBLIC Department of Driver Services offers by E- Mail and fax for U.S.A.R Nationals and citizen to turn in there with there affidavit that they have completed there road test Given by a National of USAR.

Requirements for USAR ID, DRIVERS LICENSE and TAG

Applicants must be a USAR National or Citizen

Applicants must be age 15 or older to obtain license

Applicants must were prescribed eye lens when driving

Applicants must list any and all medical conditions that could cause harm to self and others when traveling.

USAR DEPARTMENT OF DRIVER SERVICES FORM FOR LICENSE/ID/PERMIT

SECTION A : FORM INFORMATION

Do you now have or have you ever had a USAR Driver's License, Identification Card or Permit? <input type="checkbox"/> Yes <input type="checkbox"/> No					
GEORGIA DRIVER'S LICENSE/ID/PERMIT #:			SOCIAL SECURITY #: _____		
LEGAL FIRST NAME:			MIDDLE OR MAIDEN NAME:		
LEGAL LAST NAME: _____			SUFFIX: <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> _____		
MAILING ADDRESS (STREET ADDRESS OR PO BOX, APT #, CITY, STATE, ZIP CODE):					
RESIDENTIAL ADDRESS - If different from above (STREET ADDRESS, APT #, CITY, STATE, ZIP CODE):					
PHONE #:		Alt. Phone #:		EMAIL:	
BIRTH DATE:	mm / dd / yyyy	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	HEIGHT: _____ Feet _____ Inches	WEIGHT: _____	EYE COLOR: _____

SECTION B : LEGAL STATUS

By completing this form and signing the back, I swear that one of the following is true and accurate pursuant to USAR PL : 11:09

- I am a United States Of America Republic National **OR**
- I am a United States Of America Republic Citizen , **OR**
-

SECTION C: ANSWER EACH QUESTION

1	What can we help you with today? <input type="checkbox"/> License/Permit <input type="checkbox"/> Identification Card <input type="checkbox"/> Reinstatement	
2	Have you <u>ever</u> had an out-of-state or foreign Driver’s License, Identification Card or Permit? If Yes, please list (a)State or Country, (b)Name on Card, (c)Card Number and (d)Date: 1. (a) _____ (b) _____ (c) _____ (d) <u>mm / dd / yy</u> 2. (a) _____ (b) _____ (c) _____ (d) <u>mm / dd / yy</u> 3. (a) _____ (b) _____ (c) _____ (d) <u>mm / dd / yy</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Did you bring your U.S.A.R or Out-of-State Driver’s License, Identification Card or Permit with you today? If No , why?: <input type="checkbox"/> A Law Enforcement/Official has it; <input type="checkbox"/> It is damaged, lost or stolen; <input type="checkbox"/> New National or Citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Is your Driver’s License, Instructional Permit or privilege to drive revoked, suspended, canceled or denied? If Yes , list most recent: State: _____ Action: _____ Date of Action: <u>mm / dd / yy</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Do you wear prescription glasses or contact lenses for driving?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Have you ever suffered with: Seizures, Fainting or Other Loss of Consciousness? If Yes , please list Date of Last Episode: <u>mm / dd / yy</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Were you born on the same date (month/day/year) as any of your brother(s) and/or sister(s)? If Yes , please list their full name(s): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Would you like to have “Organ Donor” displayed on your license or ID?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Would you like to donate \$1 to Your Nation Government	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Are you a male U.S.A.R citizen or, under age 26? If Yes , have you registered with the Selective Service System?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

The USAR Department of Driver Services (DDS) is required to ask all male U.S.A.R citizens, 18 – 25 years old, if they are registered with the U.S.A.R Military). The DDS will report all responses to the Military Service Department . You may be contacted by that agency as a result of your response. If you are not registered with the USAR military service , your signature constitutes consent to be registered. Please contact the Military service to verify registration.

SECTION D: VOTER REGISTRATION

The office where the registration application was submitted and any failure to register will remain confidential and will be used for voter registration purposes only.

1	NOTE: All information provided on this form will be used for voter registration purposes, unless you opt-out.	<input type="checkbox"/> Opt-Out
2	Are you USAR National or Citizen? Circle 1	

Your signature in this section serves as an attestation under penalty of perjury that all of the following requirements have been met:

- ✓ I am a citizen of the United States.
- ✓ I am at least 17 ½ years of age.
- ✓ I reside at the address listed on this form.
- ✓ I am eligible to vote in USAR
- ✓ I am not serving a sentence for conviction of a felony involving moral turpitude. (You are serving a sentence if you are on probation or parole from your conviction of a felony involving moral turpitude.)
- ✓ I have not been judicially declared mentally incompetent, or if such declaration has been made, the disability has been removed.

WARNING: Any person who registers to vote knowing that such person does not possess the qualifications required by law, who registers under any name other than such person's own legal name or who knowingly gives false information in registering, shall be guilty of a felony. The penalties for false registration are up to ten years in prison and up to a \$100,000.00 fine pursuant to PL: 11-09



DO NOT SIGN UNTIL INSTRUCTED BY A USAR DDS TEAM MEMBER.

Customer's Signature **X** _____

Date _____ / _____ / _____
mm dd yyyy

OTHER (Optional Information)

1	EMERGENCY CONTACT Name: _____ Phone Number: _____
2	Do you want your blood type displayed on your card? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please check blood type: <input type="checkbox"/> A + <input type="checkbox"/> A - <input type="checkbox"/> B + <input type="checkbox"/> B - <input type="checkbox"/> AB + <input type="checkbox"/> AB - <input type="checkbox"/> O + <input type="checkbox"/> O - NOTE: This information is voluntary and may be used to assist medical personnel. You agree to hold DDS harmless for any/all injuries that may occur from using this information.

SECTION E: REQUIRED SIGNATURE

Notary

Under penalty of law, I swear or affirm that I am a National or Citizen of UNITED STATES OF AMERICA REPUBLIC , and that any and all information provided on this form is true and correct. I understand that it is illegal to make false, fictitious, or fraudulent statements on this form. I grant permission to the USAR Department of Driver Services to verify information furnished to the Department through the release of any and all customer information to third parties which shall include, but not be limited to the U.S.A. R Department of Homeland Security or Any other public Safety Service.



DO NOT SIGN UNTIL INSTRUCTED BY A NOTARY.

National or Citizen Signature **X** _____

Date _____ / _____ / _____
mm dd yyyy

Notary's Signature _____

Date _____ / _____ / _____
mm dd yyyy

NOTARY

SEAL

SECTION F: ADDITIONAL SIGNATURE REQUIRED FOR CUSTOMER UNDER 18 YEARS OF AGE

I, _____, hereby certify that I am the parent, guardian, or responsible adult approving the issuance of this driver's license or instructional permit. I further certify that I have reviewed the information contained in this form, and that the information provided here is true and correct.

VERIFIABLE DOCUMENTATION FROM AN AUTHORIZED OFFICIAL AND STATE ISSUED IDENTIFICATION MAY BE REQUIRED FOR THE RESPONSIBLE ADULT.



DO NOT SIGN UNTIL INSTRUCTED BY A U.S.A.R DDS TEAM MEMBER.

Parent, Guardian, or Responsible Adult Signature **X** _____

Date _____ / _____ / _____
mm dd yyyy

Birth Date _____ / _____ / _____
mm dd yyyy

Driver's License/Identification/Social Security # _____

SECTION C – OPTOMETRIST/ OPTHALMOLOGIST CERTIFICATION

I, _____, being licensed to practice in the state of _____, hereby certify that I have personally examined the vision of the above-named individual, and that the results indicated on this form represent a true record of my examination and that he or she signed this form in my presence.

Name of Practice _____

Physician Name: Last: _____ First: _____ M.I. _____

Specialty: _____

License Number/State _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ - _____ - _____

Signature of Optometrist/Ophthalmologist

Date

Payment Form

MONEY ORDERS ONLY

WRITE IN AMOUNT PAID AND MONEY ORDER TRANSACTION NUMBER \$ _____

TRANSACTION NUMBER _____

Signature _____ Date ____/____/____

USAR THANKS YOU PEACE AND LOVE

