

ESSEX COUNTY LICENSE REINSTATEMENT PROGRAM INTAKE FORM

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|---|--|
| Name (Last, First, Middle) | AKA #1: |
| | AKA #2: |
| Address (Number and Street) | City: |
| State: | Zip: |
| Telephone: | SS#: |
| DOB: mo day yr / / | Gender: Eye Color M F |
| DL#: | License Plate No(s): |

If we are unable to reach you, please identify an additional contact person and telephone number:

| | |
|------------------------------------|---------------|
| Name of Additional Contact Person: | Relationship: |
| Telephone: | |

| | | |
|-----------------------------|-------|-----|
| Referring Program: | | |
| Address (Number and Street) | | |
| City | State | Zip |
| Supervisor: | | |
| Telephone: | | |

Send to attn: *Carla Aidoo, License Reinstatement Program Coordinator*
 Fax: (973) 693-5721
 Telephone: (973) 693-5765