

APPLICATION FOR ABSENTEE VOTER'S 5 YEAR IDENTIFICATION CARD

State of Illinois)
County of _____) SS. Date _____
City of _____) (insert month, day, year)

To the _____ of _____
(Election Authority) (County - City)

I, _____, do solemnly swear (or affirm) that I reside
at _____ in _____
(Address) (City, Village, Township, etc.)

Precinct Number _____ and am registered and fully qualified to vote from said
address; that I am

(CHECK THE APPROPRIATE BOX)

- (1) permanently disabled
- (2) a resident of a nursing home or care facility
- (3) a holder of an Illinois Disabled Person Identification Card which indicates Class 1A or Class 2 disability. (NOTE: PHYSICIAN'S AFFIDAVIT NOT REQUIRED)

Due to the nature of the disability being specifically described in the accompanying Affidavit of Attending Physician, I am incapable of being present at the polls to vote at any election to be held within my election district. I hereby make application for the appropriate Voter Identification Card. I further swear or affirm that in the event I become capable of resuming normal voting, I will surrender my card to the Election Authority.

Address to which card is to be mailed:

(Signature of Applicant)
Signed and sworn to (or affirmed)

by _____ before
(Name of Applicant)

me, on _____
(insert month, day, year)

(SEAL)

(Signature and Official Capacity of person authorized to administer oaths)

FOR ELECTION AUTHORITY USE	
Application received _____	_____
	(insert month, date, year)
Card No. _____	_____
Issued _____	_____
	(insert month, date, year)
Expiration Date _____	_____
	(insert month, date, year)

(See reverse side for physician's affidavit)

AFFIDAVIT OF ATTENDING PHYSICIAN

State of Illinois)
County of _____) SS.
City of _____)

I, _____, do solemnly swear (or affirm) that I am a physician,
duly licensed to practice in the State of _____ that I have examined _____
and that I believe he/she is permanently incapable of being present at the polls for the following reasons:

Under penalties as provided by law pursuant to 10 ILCS 5/29-10, the undersigned certifies that the statements set forth in this certification are true and correct.

Subscribed and sworn to (or affirmed)

by _____
(Name of Physician)

(Date Licensed)

before me, on _____
(insert month, day, year)

(Signature)

NOTARY PUBLIC

(SEAL)