Dear Applicant:

The attached Application for Identification Card by an Elector Who Is Permanently Disabled must be completed to enroll in the Election Commission’s Permanently Disabled Vote by Mail Voting program. Once enrolled in the program you would automatically receive a Vote by Mail ballot for each election held in the next five (5) years.

If you wish to take part in the program, please be sure to complete the application in the areas listed below:

Check Box A or B
1) Sign and fill in the date signed
2) Complete the “Witness of Applicant’s Signature” section

Unless you are a holder of an Illinois Disabled Person Identification Card which indicates Class 1A or Class 2 disability (Box B checked) your physician must complete the following areas under AFFIDAVIT OF ATTENDING PHYSICIAN:

3) Physician’s Name
4) State that issued Physician’s License
5) Nature of Disability
6) Witness of Physician’s Signature
7) Physician’s Signature and Licensing Date

When we receive the completed application in our office, we will send you an identification card and number. You will then automatically receive a Vote by Mail ballot as well as the application for ballot, for all elections held in the next five (5) years.

If you have any questions, please contact Lucy Fonseca in this office at (630) 407-5611.

Sincerely,

Robert T. Saar
Executive Director

RTS/LF:ar
Enclosures
APPLICATION FOR IDENTIFICATION CARD BY AN ELECTOR
WHO IS PERMANENTLY DISABLED

Upon the filing of this affidavit, the DuPage County Election Commission will automatically and without any initiative on the part of the applicant, forward a completed application for ballot for any regularly scheduled election held within the next five (5) years under the jurisdiction of its Board.

State of Illinois
County of DuPage SS

To: DuPage County Election Commission

I, ______________________________, do solemnly swear or affirm that I reside at ______________________________ in the City / Village / Unincorporated Area of ______________________________ and am registered and fully qualified to vote from said address;

that I am (check the appropriate box)

☐ (A) Permanently Disabled  NOTE: PHYSICIANS AFFIDAVIT IS REQUIRED
☐ (B) A holder of an Illinois Disabled Person Identification Card which indicates Class 1A or Class 2 disability. NOTE: PHYSICIAN'S AFFIDAVIT NOT REQUIRED

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.

1 __________/__________/_________ (DATE OF BIRTH) 1 __________/__________/_________ (SIGNATURE OF APPLICANT) 1 __________/__________/_________ (TODAY'S DATE)

2 WITNESS OF APPLICANT'S SIGNATURE:

Signed and Sworn to by ______________________________
who is personally known to me on __________/__________/_________ (MONTH-DAY-YEAR)

______________________________ (SIGNATURE OF WITNESS)

Address to which card is to be mailed (if different from above):

______________________________

______________________________

______________________________

FOR ELECTION AUTHORITY USE ONLY

______________________________ (DATE APPLICATION RECEIVED)  __________/__________/_________ (DATE ISSUED)  __________/__________/_________ (EXPIRATION DATE)

AFFIDAVIT OF ATTENDING PHYSICIAN

State of Illinois
County of DuPage SS

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

6 WITNESS OF PHYSICIAN’S SIGNATURE:

Signed and Sworn to by ______________________________
Who is personally known to me on __________/__________/_________ (MONTH-DAY-YEAR)

______________________________ (SIGNATURE OF WITNESS)

UNDER PENALTIES AS PROVIDED BY LAW PURSUANT TO 10ILCS 5/29-10, THE UNDERSIGNED CERTIFIES THAT THE STATEMENTS SET FORTH IN THIS CERTIFICATION ARE TRUE AND CORRECT.

7 ______________________________ (SIGNATURE OF PHYSICIAN)  __________/__________/_________ (DATE LICENSED)

PLEASE RETURN THIS FORM TO:
DuPage County Election Commission
421 North County Farm Road, P.O. Box 1087
Wheaton, Illinois 60187-1087 (630) 407-5607