State of Illinois
County of Cook } ss.

FORM 504 DVI

AFFIDAVIT AND APPLICATION FOR DISABLED VOTER, OR RESIDENT OF NURSING HOME OR CARE FACILITY IDENTIFICATION CARD

FOR OFFICE USE ONLY	
DVI Card No.	
Date Issued	Exp. Date
Reg. No.	
Date of App. Receipt	

I, ____, certify that I am a registered voter of the _________ precinct
(Print Name)

of the_________ ward in the City of Chicago, residing at____;
(Address)

hereby make application for a Disabled Voter's or Nursing Home Resident Identification Card because I (check appropriate box):

☐ have a permanent physical incapacity
☐ am a resident of a nursing home or care facility

and have a condition or disability of such a nature as to make it improbable that I will be able to be present at the polls at any future elections. I agree that in the event I become capable of resuming normal voting, I will promptly surrender this card to the Board.

Under penalties as provided by law pursuant to Section 29-10 of the Election Code, the undersigned certifies that the statements set forth in this application are true and correct.

ADDRESS TO WHICH DVI CARD IS TO BE MAILED

Name of Street ____________________________________

Name of City____________________ State____Zip__________

Telephone No. (_____) ______________________________

Registration Record Checked by __________________________

Signature of Applicant__________________________________

Print Name______________________________________

Instructions to Applicant

If you have secured your Illinois Disabled Person I.D. Card please complete Section (A) below.
If you do not have this I.D. Card, you must have a physician sign the certification Section (B).

Notice to Signers:

Under penalties as provided by law pursuant to Section 29-10 of the Election Code, the undersigned certifies that the statements set forth in the application are true and correct.

– A –

I, ____, state that I have an Illinois Disabled Person Identification Card.

My I.D. number is__________________ and the expiration date is ____ /____ /_____ (Month/Day/Year).

Signature of Applicant______________________________________

– B –

STATE OF ILLINOIS ____________________
COUNTY OF COOK____________________ } ss.

I, ____, do hereby certify that I am a physician, duly licensed to practice medicine in the State of ______________________; that I have examined ____;
and that I verily believe he/she will be physically incapable of being present at the polls at any future elections for the following reasons:

____

____

Print Name of Physician ____________________________________

Office Address ____

Telephone No. (_____) ____________________________________

Signature of Physician_______________________________

Date Licensed ____ /____ /_____

Return to: Board of Election Commissioners, 69 W. Washington St., Suite 600, Chicago, IL 60602