10 ILCS 5/19-12.1

Suggested
Revised June, 2015
SBE No. B-6-5

APPLICATION FOR VOTE BY MAIL 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)

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

____
(Date Licensed)

____
(Signature)

____
NOTARY PUBLIC

(SEAL)