APPLICATION FOR ABSENTEE VOTER'S 5 YEAR IDENTIFICATION CARD

10 ILCS 5/19-12.1
Revised June 2015 SBE No. B-6-5

State of Illinois }
County of Grundy }
City of Morris }

Date ______________________________
(date, month, year)

To Kay T. Olson, Election Authority, of Grundy County: I, ______________________________ do solemnly swear (or affirm) that I reside at ____ in ____ Precinct Name & Number _______________________ and am registered and fully qualified to vote from said address.

I am (check one) - ______ Permanently Disabled
______ A Resident of a Nursing Home or Care Facility
______ A holder of an Illinois Disabled Person Identification Card which indicates Class 1A or Class 2 disability. (NOTE: Physician's Affidavit NOT Required)

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:

____
____
____

(SEAL)

____
(Signature of Applicant)

Voter Registration Number _____________________

Signed and sworn to (or affirmed) by
____________________________________ before me
(name of applicant)

on ____
(month, day & year)

____
(Signature & Official Capacity of person authorized to administer oaths)

ELECTION AUTHORITY USE ONLY

Application Received ________________
Card Number ______________________
Issue Date ________________________
Expiration Date ____________________

Voter's Doctor's Name _____________________________ Phone ___________________

Address ____

AFFIDAVIT OF ATTENDING PHYSICIAN

10 ILCS 5/19-12.1
Revised 07/1999 SBE No. B-6-5
Reverse Side SBE No. B-6-5

State of Illinois }
County of Grundy }
City of Morris }

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

____

____

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

____ (Physician's Signature)

__________________________________ (Date Licensed)

Subscribed and sworn to (or affirmed) by _______________________________________ (NAME OF PHYSICIAN)

before me, on ____ (INSERT MONTH, DAY, YEAR)

(SEAL)

_____________________________________ (NOTARY PUBLIC SIGNATURE)