



# DuPage County Election Commission

J. P. "Rick" Carney  
*Chairman*

Jeanne McNamara  
*Vice Chairman*

Charlotte Mushow  
*Secretary*

Robert T. Saar  
*Executive Director*

Dear Applicant:

The following *Application for Identification Card by an Elector Who Is Permanently Disabled* must be completed to enroll in the Election Commission's Permanently Disabled Absentee Voting program. Once enrolled in the Program you would automatically receive an absentee 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:

1. Fill in your Name, Address and Township/Precinct
2. Fill in your Date of Birth, Signature and Today's Date
3. Complete the Witness of Applicant's Signature section

Your physician must complete the following areas under **AFFIDAVIT OF ATTENDING PHYSICIAN**:

4. Physician's Name
5. State that issued Physician's License
6. Name of Patient/Applicant
7. Nature of Disability
8. Witness of Physician's Signature
9. 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 an absentee 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 Cindy in this office at 630-407-5607.

Sincerely,

A handwritten signature in black ink that reads "Robert T. Saar".

Robert T. Saar  
Executive Director

RTS:ck

# 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**

**1**  
I, \_\_\_\_\_, do solemnly swear or affirm that I reside  
(NAME OF APPLICANT)  
at \_\_\_\_\_ in the \_\_\_\_\_ City / Village / Unincorporated Area  
(STREET ADDRESS) (CIRCLE ONE)  
of \_\_\_\_\_ Township of \_\_\_\_\_ Precinct Number \_\_\_\_\_ and  
(MUNICIPALITY THAT PROVIDES POSTAL SERVICE) (TOWNSHIP) (PRECINCT NUMBER)

am registered and fully qualified to vote from said address; that I am (check the appropriate box)

- (A) Permanently Disabled (**NOTE: PHYSICIAN'S AFFIDAVIT IS REQUIRED**) - The nature of the disability being specifically described in the accompanying Affidavit of Attending Physician
- (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.

**2** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(DATE OF BIRTH) (SIGNATURE OF APPLICANT) (TODAY'S DATE)

**3 WITNESS OF APPLICANT'S SIGNATURE:**  
Signed and Sworn to by \_\_\_\_\_  
(NAME OF APPLICANT)  
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	FOR ELECTION AUTHORITY USE ONLY	FOR ELECTION AUTHORITY USE ONLY	FOR ELECTION AUTHORITY USE ONLY
____ / ____ / ____ (DATE APPLICATION RECEIVED)		____ / ____ / ____ (DATE ISSUED)	____ / ____ / ____ (EXPIRATION DATE)

## AFFIDAVIT OF ATTENDING PHYSICIAN

State of Illinois }  
County of DuPage } ss.

I, **4** \_\_\_\_\_, do solemnly swear or affirm that I am  
(NAME OF PHYSICIAN)  
a physician, duly licensed to practice in the State of **5** \_\_\_\_\_, I have examined  
(DESIGNATE STATE)

**6** \_\_\_\_\_ and I believe he/she is permanently incapable of being present at  
(NAME OF PATIENT/APPLICANT)

the polls for the following reason(s): **7**

**8 WITNESS OF PHYSICIAN'S SIGNATURE:**  
Signed and Sworn to by \_\_\_\_\_  
(NAME OF PHYSICIAN)  
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.

**9** \_\_\_\_\_  
(SIGNATURE OF PHYSICIAN)  
\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(DATE LICENSED)