

APPLICATION FOR ABSENTEE VOTER'S 5 YEAR IDENTIFICATION CARD

State of Illinois)
) SS.
County of Will)

Date: _____

To: NANCY SCHULTZ VOOTS, COUNTY CLERK OF WILL COUNTY

I, _____, do solemnly swear (or affirm) that I
reside at _____ in _____ Township
(Address)
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)

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)

Signed and sworn to (or affirmed)

by _____ before

(Name of Applicant)

me, this _____ day of

_____, 20____.

(Signature and Official Capacity of person authorized to administer oaths)

FOR ELECTION AUTHORITY USE	
Application received _____,	20____
Card No. _____	
Issued _____,	20____
Expiration Date _____,	20____

(See reverse side for physician's affidavit)

AFFIDAVIT OF ATTENDING PHYSICIAN

State of Illinois)
) SS.
County of Will)

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 reason (s):

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.

Subscribed and sworn to (or affirmed)

(Date Licensed)

By _____
(Name of Physician)

before me, this _____ day of
_____, 20____

(Signature)

NOTARY PUBLIC

(Seal)