Robert L. Quinn
Commissioner of Safety

NH DEPARTMENT OF SAFETY
Division of Motor Vehicles
23 Hazen Drive, Concord, NH 03305
Tele: (603) 227-4020 TDD Access Relay NH 7-1-1

John C. Marasco
Director of Motor Vehicles

Medically Recognized Disorder Indication

Please note: This form may not be used for name or address changes. Please fill out a "Record Change Request" form (DSMV 30) for any name and/or address changes. Name changes will require authorized supporting documentation.

Name on Current NH Driver License or Non-Driver ID: _____

Date of Birth: _____ DL or NDID # _____

Address: _____
Street Name or PO Box No. *Town or City* *State* *Zip Code*

My signature below authorizes the Division to add a medically recognized indication of Autism Spectrum Disorder to my driver license/identification card pursuant to RSA 263:41-b.

Signature of Applicant: _____ Date: _____
Signed under penalty of unsworn falsification (RSA 641:3)

The below certification must be completed by a Licensed Physician.

In my professional opinion, the applicant has been diagnosed with the following condition:

☐ Autism Spectrum Disorder

Name of Licensed Physician (*please print*): _____

Name of Practice: _____

Address: _____
Street *Town or City* *State* *Zip Code*

Telephone Number: _____

I certify, under the penalty of unsworn falsification pursuant to RSA 641:3, that the person whose name appears above is under my treatment and care for the above indicated diagnosis.

Signature of Licensed Physician: _____ Date: _____