



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

**HEALTH CARE PROVIDER CERTIFICATION OF ELIGIBILITY
FOR PERMANENTLY DISABLED IDENTIFICATION CARD**

SECTION A – CUSTOMER INFORMATION

FULL LEGAL NAME	DATE OF BIRTH	DL / ID / SSN OF APPLICANT	
ADDRESS	CITY	STATE	ZIP CODE

A resident who is under seventeen years of age and eligible for an identification card with an expiration date that is in accordance with division (A)(8)(b) of section 4507.52 of the R.C. may apply for the issuance of an identification card under this section without payment of any fee, including any document processing fees.

SECTION B – HEALTH CARE PROVIDER CERTIFICATION

NAME OF HEALTH CARE PROVIDER		LICENSE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

OHIO REVISED CODE (R.C.) SECTIONS 4507.50 and 4507.52 STATES IN PART THAT: Any non-driver identification card that is issued to a resident of Ohio who is under seventeen years of age and permanently or irreversibly disabled must be issued with an eight (8) year expiration date and be exempt from the identification card fees. The disability must be confirmed by a physician or health care provider:

I, X _____ on _____ certify that the above named
SIGNATURE OF HEALTH CARE PROVIDER DATE

applicant is permanently or irreversibly disabled, with no present indication of recovery as defined above by R.C. section 4507.52(b).

By completing this form, I am hereby affirming that **ALL of the requirements** of section 4507.50 and 4507.52 have been met and that all the information contained on this form is true and accurate. I understand that providing false information may constitute a criminal offense of falsification under section 2921.13 of the R.C. and is a misdemeanor of the first degree.

SIGNATURE OF APPLICANT X	DATE
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NOTE: This document is valid for 30 days from the date indicated by the Heath Care Provider.