OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

APPLICATION FOR IDENTIFICATION CARD FOR HEARING-IMPAIRED DRIVER
(Please Type or Print)

BMV USE ONLY

CARD NO. _____
DATE ISSUED _____
EXP. DATE _____

WHO QUALIFIES: Any person who has a hearing loss of forty decibels or more in one or both ears per Ohio Revised Code (R.C.) 4507.141.

INSTRUCTIONS: Application must be completed in the name of the hearing-impaired person. Application must include signature of the hearing-impaired person. Physician's certification **must be completed and signed by a licensed physician including his / her physician's license number.**

WARNING: APPLICANT GIVING FALSE INFORMATION IS SUBJECT TO PROSECUTION (R.C. SECTION 2921.13).

NAME OF HEARING-IMPAIRED PERSON		SOCIAL SECURITY NUMBER (Optional)	
ADDRESS (Street)	CITY	STATE **OHIO**	ZIP CODE
COUNTY	DRIVER LICENSE NUMBER		
SIGNATURE OF HEARING-IMPAIRED PERSON **X**		DATE	

HEARING IMPAIRED I.D. CARD

☐ Original ☐ Replacement ☐ Renewal

PREVIOUS CARD WAS ☐ **Lost** ☐ **Damaged** ☐ **Stolen**

To be COMPLETED by applicant's personal **PHYSICIAN**

PHYSICIAN'S CERTIFICATION OF APPLICANT'S HEARING IMPAIRMENT

NAME OF HEARING-IMPAIRED PERSON			
ADDRESS (Street)	CITY	STATE **OHIO**	ZIP CODE
HEARING LOSS IN DECIBELS MUST BE INDICATED ON LINES BELOW RIGHT EAR LEFT EAR BOTH			
EXPECTED DURATION OF HEARING IMPAIRMENT ☐ Less than 12 months (Hearing impairment certified until _____) Date ☐ Twelve months or more / Permanent			

I, (Signature of **PHYSICIAN)** **X**_____ certify the above named applicant has a hearing impairment as defined below by R.C. Section 4507.141.

PHYSICIAN'S NAME (type or print)		PHYSICIAN'S LICENSE NUMBER		
ADDRESS (Street)	CITY	STATE	ZIP CODE	DATE

Send completed application to: OHIO BUREAU OF MOTOR VEHICLES
ATTN: SPECIAL CASE UNIT
P.O. BOX 16784
COLUMBUS, OH 43216-6784

RESTRICTED