Suggested
Revised June, 2015
SBE No. B-6-5

APPLICATION FOR VOTE BY MAIL VOTER'S 5 YEAR IDENTIFICATION CARD

State of Illinois)
County of _____) SS. Date_____
City of. _____) *(insert month, day, year)*

To the _____ of _____
(Election Authority) *(County - City)*

I, _____,do solemnly swear (or affirm) that I reside at _____ in _____
(Address) *(City, Village, Township, etc.)*

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)*

Due to 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:

_____

_____

_____

_____
(Signature of Applicant)

Signed and sworn to (or affirmed)

by _____ before
(Name of Applicant)

me, on _____
(insert month, day, year)

(SEAL)

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

FOR ELECTION AUTHORITY USE

Application received _____
(insert month, date, year)

Card No._____

Issued _____
(insert month, date, year)

Expiration Date _____
(insert month, date, year)

(See reverse side for physician' s affidavit)

Reverse Side of
SBE No. B-6-5

AFFIDAVIT OF ATTENDING PHYSICIAN

State of Illinois)

County of _____) SS.

City of _____)

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 reasons:

_____

_____

_____

_____

Under penalties as provided by law pursuant to 10 ILCS 5/29-10, the undersigned certifies that the statements set forth in this certification are true and correct.

Subscribed and sworn to (or affirmed)

by _____
(Name of Physician)

before me, on _____
(insert month, day, year)

_____
(Date Licensed)

_____
(Signature)

_____
NOTARY PUBLIC

(SEAL)