FORM 504 DVI

State of Illinois
County of Knox } ss.

AFFIDAVIT AND APPLICATION FOR DISABLED VOTER, OR RESIDENT OF NURSING HOME OR CARE FACILITY IDENTIFICATION CARD

FOR OFFICE USE ONLY	
DVI Card No.	
Date Issued	Exp. Date
Reg. No.	
Date of App. Receipt	

I, _____ (Print Name), certify that I am a registered voter of the _____ precinct of the _____ ward in the City of Galesburg, residing at _____ (Address);

hereby make application for a Disabled Voter's or Nursing Home Resident Identification Card because I (check appropriate box):

☐ have a permanent physical incapacity

☐ am a resident of a nursing home or care facility

and have a condition or disability of such a nature as to make it improbable that I will be able to be present at the polls at any future elections. I agree that in the event I become capable of resuming normal voting, I will promptly surrender this card to the Board.

Under penalties as provided by law pursuant to Section 29-10 of the Election Code, the undersigned certifies that the statements set forth in this application are true and correct.

ADDRESS TO WHICH DVI CARD IS TO BE MAIL

Name of Street _____

Name of City _____ State_____ Zip_____

Telephone No. (____) _____

Signature of Applicant_____

Print Name _____

Registration Record Checked by _____

Instructions to Applicant

If you have secured your Illinois Disabled Person I.D. Card please complete Section (A) below.
If you do not have this I.D. Card, you must have a physician sign the certification Section (B).

Notice to Signers:

Under penalties as *provided by law pursuant* to Section 29-10 of the Election Code, the undersigned certifies that the statements set *forth in the application are true and correct.*

- A -

I,_____, state that I have an Illinois Disabled Person Identification Card.

My I.D. number is _____ and the expiration date is ___ / ___ / _____ (Month/Day/Year).

Signature of Applicant _____

- B -

STATE OF ILLINOIS _____
COUNTY OF KNOX _____ } SS

I, _____, do hereby certify that I am a physician, duly licensed to practice medicine in the State of _____; that I have examined _____ and that I verily believe he/she will be physically incapable of being present at the polls at any future elections for the following reasons:

_____

_____

Print name of Physician_____

Office Address _____

Telephone No. (___) _____

Signature of Physician _____

Date Licensed ___ / ___ / _____

Return to: Board of Elections, 55 W. Tompkins St, P.O. Box 1387, Galesburg, IL 61402-1387