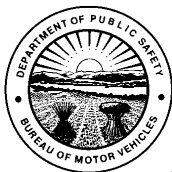

OHIO BUREAU OF MOTOR VEHICLES

BMV USE ONLY
CARD NO. ______________
DATE ISSUED ____________
EXP. DATE _______________

APPLICATION FOR IDENTIFICATION CARD FOR HEARING-IMPAIRED DRIVER

(Please Type or Print)

WARNING: APPLICANT GIVING FALSE INFORMATION IS SUBJECT TO PROSECUTION (O.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		

X ____

SIGNATURE OF HEARING-IMPAIRED PERSON DATE

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 the Ohio Revised Code Section 4507.141

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

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

Send completed applications to: OHIO BUREAU OF MOTOR VEHICLES
ATTN: SPECIAL CASE / MEDICAL
P O BOX 16784
COLUMBUS OH 43216-6784

BMV 6316 8/04