Division of Motorist Services
2900 Apalachee Parkway
Tallahassee, Florida 32399
www.flhsmv.gov

Terry L. Rhodes
Executive Director

Robert Kynoch
Division Director

Application for Developmental Disability Designation

Applicant Information

Last	First	MI	Date of Birth

Mailing Address:	City	ZIP

Residential Address:	City	ZIP

_____ Signature of Applicant, Parent, or Legal Guardian

_____ Applicant's ID/DL Number, if applicable

_____ Date

Physician's Statement of Certification

Print Name of Physician	Physician's Certificate/License Number

Business Address	City	State	ZIP

_____ (**Print Applicant's Name**) is applying for a disability designation on their

DL ☐ ID ☐ ***(Indicate whether this is for a driver license or identification card)***

In my professional opinion, this individual has been diagnosed as having a disability as defined in section 393.063, Florida Statutes.

_____ Signature of Physician

_____ Contact Number

_____ Date