Florida Department of Highway Safety and Motor Vehicles

Application for Developmental Disability Designation

Please submit this form to your local tax collector office or driver license service center

https://www.flhsmv.gov/locations/

Applicant Information

Last Name	First Name	Middle Initial	Date of Birth

Mailing Address	City	Zip

Residential Address	City	Zip

Signature of Applicant, Parent, or Legal Guardian	Applicant DL/ID Number, if applicable	Date

Physician Statement of Certification

Print Name of Physician	Physician Certificate/License Number

Business Address	City	State	Zip

_____ (**Print Applicant 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