STATE OF MISSISSIPPI
DEPARTMENT OF PUBLIC SAFETY

PHYSICIAN CERTIFICATION FORM

Patient Information (Please type or print legibly)

Driver Name: ______________________________ Date of Birth: ___ / ___ / _____

Driver Address: ______________________________ Driver License/ID Number: ____________________

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I, ______________________________ hereby authorize my physician to release the medical information listed below to the Mississippi Department of Public Safety.

Patient's Signature ______________________________ Date ____________________

Certification of Diabetes (To be completed by physician)

☐ I certify that this patient has been diagnosed with diabetes.

Please check all that apply: ☐ Injection (shot) Dependent ☐ Diet Controlled ☐ Oral (pill) Dependent

Certification of Hearing-Impaired Driver (To be completed by physician)

☐ I certify that this patient has been diagnosed as hearing impaired. The following standard is used to determine whether a driver can be issued a Hearing-impaired Driver indicator on their driver license: a) Must first perceive forced whispered voice > 5 ft., with or without hearing aid, or b) average hearing loss in better ear < 40 dB

Please check all that apply: ☐ Hearing aid used for tests ☐ Hearing aid required to meet standard

Persons with Disabilities ID Card (To be completed by physician)

☐ I certify that this driver meets one or more of the following conditions:

Please check all that apply:

☐ Cannot walk 200 Feet without stopping to rest; or
☐ Cannot walk without the use of an assistive device; or
☐ Is severely limited in his/her ability to walk due to an arthritic, neurological, or orthopedic condition.

☐ The applicant's disability creates mobility limitations which prevent him/her from climbing stairs or from otherwise entering normally designed buses or other vehicles normally used for public transportation.

☐ The applicant's disability is a permanent disability and one that which cannot be corrected.
☐ The applicant's disability is a temporary disability which will last for a period of approximately ____________________.

Physician Information

I hereby certify that the person listed above is currently under my care and has been diagnosed with the condition indicated and that I am a licensed physician.

Physician's Name (Please print) ______________________________

Physician's Signature ______________________________ Date ____________________
(Signature Must be in BLUE Ink)

Medical License No. ______________________________

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