Communication Disability Verification Form

In accordance with section 3304.23 of the Ohio Revised Code (R.C.), this form may be completed and submitted to add or remove persons/license plate numbers from the database of those who have been diagnosed with a communication disability or a disability that can impair communication.

- R.C. 3304.23 defines a *communication disability* as a human condition involving an impairment in the human's ability to receive, send, process, or comprehend concepts or verbal, nonverbal, or graphic symbol systems that may result in a primary disability or may be secondary to other disabilities.
- R.C. 3304.23 defines a *disability that can impair communication* as a human condition with symptoms that can impair the human's ability to receive, send, process, or comprehend concepts or verbal, nonverbal, or graphic symbol systems.
- R.C. 5502.08 specifies that information in the communication disability database is not a public record.

INSTRUCTIONS

REQUEST TO BE ADDED TO THE DATABASE

Sections A and B: The individual with a communication disability or disability that can impair communication, or parent or guardian, must complete and sign Sections A and B of the document.

- Any person diagnosed with a communication disability or a disability that can impair communication who is eighteen years of age or older
- Any parent or guardian of a minor child or a ward diagnosed with a communication disability or a disability that can impair communication

Section C: This section must be completed and signed by a psychiatrist or other physician, a psychologist, a clinical nurse specialist, or a certified nurse practitioner.

REQUEST REMOVAL FROM THE DATABASE

Complete and sign sections A and B only.

RETURN THE FORM PROMPTLY

Completed forms may be mailed, scanned and emailed, or delivered to:

Mail:	Ohio Bureau of Motor Vehicles, Attention: Remittance/DPU PO Box 16521, Columbus, Ohio 43216-6521
Email:	Scan and send to VIS-Administration@dps.ohio.gov
In-person:	Deliver to any Deputy Registrar/Ohio Bureau of Motor Vehicles office

PAYMENT

This service is offered at no cost. Please allow 15 business days for processing. Incomplete, illegible, or unsigned forms cannot be processed.

For additional information, please call Opportunities for Ohioans with Disabilities at 614-438-1200 or go to www.ood.ohio.gov/communicationdisabilitylaw.

COMMUNICATION DISABILITY VERIFICATION FORM

I would like to *(Please choose one):*

☐ Be included in the database. *(Sections A, B, and C)*
☐ Be removed from the database. *(Sections A and B only)*

SECTION A

To be completed by person with disability (if able and age 18 or over) or by the parent or guardian of person with disability. Please type or print legibly all requested information.

NAME OF PERSON WITH DISABILITY (REQUIRED)		DL / ID OF PERSON WITH DISABILITY (REQUIRED IF APPLICABLE)	
STREET ADDRESS		CITY	
STATE	ZIP CODE	COUNTY	TELEPHONE NUMBER
PERSON COMPLETING APPLICATION (REQUIRED IF APPLICABLE)		RELATIONSHIP TO APPLICANT (REQUIRED IF APPLICABLE)	
EMAIL ADDRESS FOR CONFIRMATION (OPTIONAL)			

The information above is true and accurate to the best of my understanding.

SIGNATURE OF APPLICANT OR PERSON COMPLETING APPLICATION	DATE SIGNED

SECTION B

To be completed by person with disability (if able and age 18 or over) or by the parent or guardian of person with disability. Please type or print legibly all requested information.

R.C. 3304.23 allows an applicant to list the license plate number of each vehicle owned, operated, or regularly occupied by the person diagnosed with a communication disability or a disability that can impair communication.

LICENSE PLATE NUMBER(S) (COMPLETE AS MANY AS NECESSARY)

1.	2.	3.
4.	5.	6.
7.	8.	9.

SECTION C

To be completed by a psychiatrist or other physician, a psychologist, a clinical nurse specialist, or a certified nurse practitioner. Please type or print legibly all requested information. All information below is required for inclusion in the database.

NAME OF HEALTH CARE PROVIDER			PROFESSIONAL LICENSE NUMBER	ISSUING STATE
BUSINESS ADDRESS			TITLE	
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER	

I certify that the person named above has been diagnosed with a communication disability or a disability that can impair communication as defined by R.C. section 3304.23.

SIGNATURE OF HEALTHCARE PROVIDER (REQUIRED)	DATE SIGNED

Warning: Knowingly making a false statement on this form constitutes falsification, a first-degree misdemeanor punishable by criminal fines and imprisonment, and may result in civil liability (R.C. 2921.13).