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APPLICATION FOR HEARING AND SPEECH IMPAIRED

DEPARTMENT OF REVENUE AND TAXATION MOTOR VEHICLE DIVISION

Hours of Operation: Monday-Friday 8am-5pm

Purpose: To alert law enforcement and others to the driver's condition **(not for special parking privileges).** Medical Certification must be completed by a person licensed to practice medicine or an audiologist certified by the American Speech, Language and Hearing Association. Applicant must be unable to hear or understand normal speech, with or without a hearing aid, in optimal conditions.

Applicant must provide one of the following valid identification: Driver's License, Guam I.D., Naturalization Certification, Green Card, Firearms I.D. Passport, or Military ID.

PRIVACY ACT NOTICE: The furnishing of your Social Security Number is required pursuant to Section 3101, Title 16, Guam Code Annotated and Section 405 (c) (1) (C), Title 42, United States Code. We need this information for the purpose of administering the Vehicle Code of Guam.

NAME: _____ _____ _____ SOCIAL SECURITY NO.: _____
(LAST) (NAME) (INT)

MAILING ADDRESS: _____ _____
(STREET NUMBER/P.O.BOX) ZIP CODE

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____ SEX: ____ PHONE NO.: _____

1. Please check the appropriate box: [ ] Placard(s) [ ] License Plate [ ] Driver's License [ ] Guam ID Card
2. Do you have a current hearing impaired parking placard? Yes__ No ____ if yes, Placard No(s): _____
3. Do you have a current hearing impaired license plate? Yes_____ No ___ If yes, License Plate Number: _____ Expiration Date: _____
4. Does your current Driver's License indicate the HSD (Hearing and Speech Disability) restriction? Yes___ No___
5. Does your current Guam ID indicate the HSD (Hearing and Speech Disability) restriction? Yes___ No____

I hereby give my full authorization to release any information pertaining to my medical condition to process this application. I further declare under penalty of perjury that the foregoing is true and correct and that I am the same person described in this application.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

MEDICAL CERTIFICATION

I, the undersigned, being duly licensed to practice in Guam, certify under penalty of perjury that I am personally aware of the degree that the person identified in this application has a Hearing and Speech Impaired Disability.

_____ _____
Physician's Signature/Date Print Name

_____ _____
Clinic Address/Telephone

(Rev3/10)