

**PHYSICIAN'S CERTIFICATE**  
**SPECIAL PROGRAM FOR PHYSICALLY HANDICAPPED VOTERS**

Parish of \_\_\_\_\_ Date \_\_\_\_\_

I hereby certify to the correctness of the following information regarding  
\_\_\_\_\_, who is applying for participation in the  
special program for physically handicapped voters under the provisions of  
Chapter 7A of the Louisiana Election Code.

(1) Diagnosis of applicant's disability in layman's terms is:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(2) Prognosis of applicant's condition and probable duration:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In my professional opinion, considering the applicant's physical disability,  
applicant is

\_\_\_\_\_ UNABLE to appear to vote absentee in person before the registrar of  
voters or at one of the polls on election day.

\_\_\_\_\_ ABLE to appear to vote absentee in person before the registrar of  
voters or at the polls on election day.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Daytime Telephone Number

\_\_\_\_\_  
Physician's Name – Printed or Typed

\_\_\_\_\_  
Address

**NOTICE TO PHYSICIANS: Knowingly making false statements herein  
constitutes an election offense and is punishable by a fine or imprisonment,  
or both.**