



Medical Certificate

(To be submitted by the doctor of the person with disability)

Applicant's name and surname:		Applicant's ID card N°:	
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Type of impairment <i>(Tick where applicable)</i>	Services required <i>(Tick where applicable)</i>
Physical	Exemption from payment of the Car Registration Tax
Intellectual	
Impaired vision	Exemption from payment of the Car License
Psychological	
Impaired hearing	

Please give a clear and accurate diagnosis and how this is affecting the person in question.
The more detailed the information given, the faster this application can be processed.

The disability started:	<input type="checkbox"/> at birth <input type="checkbox"/> when the person was ____ years old		
Applicant can sign on own behalf	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the applicant have a permanent mobility problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Doctor's signature		Date	
Registration N°		Official stamp	