Mississippi Department of Public Safety
Driver Services Bureau

Certification of Diabetes

(Please type or print legibly)

Patient Information

Full Name: _____
(First) (Middle) (Last)

Address: _____
(Street)

_____
(City) (State) (Zip)

Date of Birth _____ (Driver License Number _____

I, _____ hereby authorize my physician listed below to release the necessary medical information to the Department of Public Safety in order that I may be issued a special driver license or identification card that will help identify me as a diabetic.

Physician Information

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

Physicians Name (Please Print) _____

Physicians Signature _____ Date _____
(Signature Must be in BLUE Ink)

Medical License No. _____

Check Appropriate Box:
- ☐ Insulin Injection (shot) Dependent
- ☐ Byetta Injection (shot)
- ☐ Oral (pill) Dependent
- ☐ Diet Controlled

DE 16-A (Revised March 2010)