



TEXAS DEPARTMENT OF PUBLIC SAFETY
5805 N LAMAR BLVD · BOX 4087 · AUSTIN, TEXAS 78773-0001
<https://www.dps.texas.gov>

PHYSICIAN/PSYCHIATRIST'S STATEMENT

(Please type or print)

Texas Transportation Code §521.142(h) allows the Texas Department of Public Safety to include on an individual's driver license or identification card any health condition that may impede the individual's communication with a peace officer.

The health condition must be evidenced by this signed statement from a licensed physician or licensed psychiatrist. By providing this information, the phrase "Communication Impediment" or "Deaf or Hard of Hearing" will be printed on the driver license (DL) or identification card (ID).

The communication impediment form is to be filled out by both the Patient and the Physician/Psychiatrist. This form must be completed and returned by the applicant to the Texas Department of Public Safety before the indicator is added to the DL or ID.

Communication Impediment Indicator

This group needs more time to respond to a police officer. Examples of the conditions include:

- Autism (including Asperger Syndrome)
- Mild Intellectual Disability
- Down Syndrome
- Parkinson's Disease
- Speech and Language Disorders (mutism, stuttering, speech delay Aphasia and Spasmodic Dysphonia)
- Post-Traumatic Stress Disorder
- Brain Injury
- Cerebral Palsy

Deaf or Hard of Hearing Indicator

This group communicates through different methods, including visual language like ASL or assistive technology:

- Deaf
- Hard of Hearing

This form is a confidential driver record document per Chapter 730 of the Texas Transportation Code.

NOTE: All other health conditions may be noted by the customer on the reverse side of the DL or ID by marking the directive to physician and writing the phone number for the physician.



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(Please type or print)

Patient Information

First Name: _____
Last Name: _____
Middle Name: _____
DL/ID Number: _____
Patient's Signature: _____
Date: _____

Physician/Psychiatrist Information (To Be Completed By A Physician/Psychiatrist)

First Name: _____
Last Name: _____
Office Address: _____
Office Telephone Number: _____
Medical License Number: _____
State: _____
Patient's Medical Condition: _____
Physician's/Psychiatrist's Signature: _____
Date: _____

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