



INVISIBLE DISABILITY DISCLOSURE

Wisconsin Department of Transportation
MV2167 4/2019 s.341.08 and s.343.14 Wis. Stats.



Wisconsin Department of Transportation
Medical Review
P.O. Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
Fax: (608) 267-0518
Email: dmvmedical@dot.wi.gov

Applicant Name	Driver License or ID Card Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <small>1 2 3 4 5 6 7 8 9 10 11 12 13 14</small>
Street Address	Birth Date <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>M M D D Y Y Y Y</small>
City, State ZIP Code	(Area Code) Telephone Number

You may use this form to disclose on your Wisconsin driver license, identification card and vehicle registration record that you have a disability that may not be immediately apparent to another person. Please send the completed form to the address above or present it at a Wisconsin DMV Service Center.

The disclosure that you make will be available to law enforcement officers and employees of the Wisconsin Department of Transportation.

I have an invisible disability that I wish to disclose to law enforcement officers and that may include:

- Appears deaf or unable to understand
- Has difficulty speaking or communicating
- Engages in repetitive or self-stimulating behaviors such as rocking or hand flapping
- Appears anxious, nervous or upset
- Becomes agitated due to physical contact or stressful situations
- Acts indifferent or unresponsive
- Other (*provide brief description*): _____

You may also use this form to request that the Department remove from your Wisconsin driver license, identification card and vehicle registration record any information related to your prior disclosure of a disability that may not be immediately apparent to another person.

- I previously disclosed to the Department that I have an invisible disability and now request that the Department remove any information related to my prior disclosure of an invisible disability from the record.

I certify that the information on this form is true under penalty of perjury. (s.343.14(5) Wis. Stats.)

X _____
(Signature)

(Date)