

**INFORMATION FOR THE VIRGINIA TRANSPLANT COUNCIL**

Yes, I would like to remain or become an organ, eye and tissue donor.



**IDENTIFICATION CARD APPLICATION FOR MINORS UNDER AGE 15**

DL 5 (07/01/2014)

LOG NUMBER

**Purpose:** Minors under age 15 use this form to apply for an identification card.  
**Instruction:** Print in ink or type. Virginia Code requires that you provide DMV with the information on this form (including your social security number). This information is confidential and may be disseminated only in accordance with Virginia Code §46.2-345.

**ELIGIBILITY REQUIREMENTS**

To qualify for an identification card for a minor, the applicant must be a Virginia resident under age 15.  
 Parent/Legal Guardian, check the box if you give consent for this minor to remain or become an organ, eye and tissue donor and for the Department of Motor Vehicles (DMV) to display this information on his/her identification card.

PARENT/LEGAL GUARDIAN NAME (print)	PARENT/LEGAL GUARDIAN SIGNATURE	DATE (mm/dd/yyyy)
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**APPLICATION TYPE**

<input type="checkbox"/> Original	If you are applying for a replacement ID Card check one the following:
<input type="checkbox"/> Renewal	
<input type="checkbox"/> Replacement	
<input type="checkbox"/> I am surrendering my current ID Card. <input type="checkbox"/> I certify my current ID Card is unavailable for surrender because it is: <input type="checkbox"/> lost <input type="checkbox"/> stolen <input type="checkbox"/> destroyed/mutilated	

**APPLICANT INFORMATION**

SOCIAL SECURITY NUMBER (optional)	BIRTH DATE (mm/dd/yyyy)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
FULL LEGAL NAME (last) (first) (middle) (suffix)			
CITY OR COUNTY OF RESIDENCE	WEIGHT	HEIGHT FT. IN.	HAIR COLOR
STREET ADDRESS		CITY	STATE ZIP CODE
PREVIOUS NAME (if changed)		TELEPHONE NUMBER ( )	
MAILING ADDRESS (if different from above - this address will appear on your ID Card.)		CITY	STATE ZIP CODE

**SPECIAL INDICATOR REQUEST**

Please show the following indicator(s) on my ID card:  
 Insulin-dependent diabetic  Speech impairment  Hearing impairment (license only)  Intellectual disability (IntD)  Autism spectrum disorder (ASD)  
 Must submit required physician statement.

**CERTIFICATION**

I certify that my child/ward is a resident of Virginia and is the person described above.  
 I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

PARENT/LEGAL GUARDIAN NAME (print)	PARENT/LEGAL GUARDIAN SIGNATURE	DATE
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**FOR DMV USE ONLY — DO NOT WRITE BELOW THIS LINE**

REMARKS/PAID STAMP	CUSTOMER NUMBER	TRANSACTION TYPE <input type="checkbox"/> ORIGINAL <input type="checkbox"/> REISSUE <input type="checkbox"/> DUPLICATE <input type="checkbox"/> RENEWAL	FEE
	PROOF OF ID (primary)	PROOF OF ID (secondary)	
	PROOF OF SOCIAL SECURITY (specify)	PROOF OF RESIDENCY	
	PROOF OF LEGAL PRESENCE (specify)		
	Document Type	Document Number	Expiration Date (mm/dd/yyyy)
	Document Type	Document Number	Expiration Date (mm/dd/yyyy)
	Document Type	Document Number	Expiration Date (mm/dd/yyyy)
CSR SIGNATURE AND NUMBER		DOCUMENT VERIFIER SIGNATURE AND NUMBER	