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)