Louisiana Department of Public Safety and Corrections Office of Motor Vehicles

Medical Examiner's Certification of Seizure Disorder

This form is to be completed by a qualified medical professional licensed in Louisiana or another state or territory of the United States.

Applicant Information (to be completed by the applicant)					
Name		Date of Birth			
Race		Sex: ☐ Male ☐ Female		Credential #	
Address		City, State		ZIP	

Diagnosis Information (to be completed by the licensed medical professional)		
I certify that _____ has been diagnosed with seizure disorder, and meets the requirements for the seizure disorder designation, as defined in R.S. 32:412. Date of last seizure_____(**Required).**		
Medical Professional's Signature	Date	Address
Medical Professional's Printed Name		City, State, ZIP
Medical Professional's Title	License #	Telephone Number

To be completed by the Office of Motor Vehicles			
Date	Analyst's Initials	Badge #	Office #