Louisiana Department of Public Safety and Corrections

OFFICE OF MOTOR VEHICLES

PHYSICIAN'S CERTIFICATION FOR SEAT BELT EXEMPTION

APPLICANT'S NAME: _____

DATE OF BIRTH: _____RACE/SEX: _____DRIVER'S LICENSE #: _____

PHONE NUMBER: _____ EMAIL ADDRESS: _____

ADDRESS: _____
City State Zip

I certify that _____ has a physical or mental disability which prevents appropriate restraint in a safety belt and qualifies for a seat belt exemption card. I understand that willful and false certification shall subject me to fines/imprisonment as outlined in R.S. 32:295.1 (D)(9).

The reason the use of a restraint is inappropriate is: _____

_____

☐ **TEMPORARY DISABILITY**. The period of time for which the disability will prevent the above-named individual's use of a seat belt will be from _____ through _____.

☐ **PERMANENT DISABILITY**. Condition will not improve.

_____
Physician's Signature Physician's Printed Name Date

_____
Physician's Address City State Zip Telephone #

TO BE COMPLETED BY MV OFFICER ONLY

Card # _____ Operator # _____ Office # _____ Date Issued _____

DPSMV2012 (R0618)

P.O. BOX 64886, BATON ROUGE, LOUISIANA 70896-4886

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