Louisiana Department of Public Safety and Corrections
Office of Motor Vehicles
PO Box 64886, Baton Rouge, LA 70896-4886

Medical Examination Form DPSMV2302 (R 07/2026)

The bearer of this medical examination form is being required to undergo an examination by a physician. Authority for the requirement is based on laws of the State of Louisiana relating to the issuance of drivers' licenses. The completed report of examination will be used by the Department of Public Safety and Corrections as a guide in making a final determination on the bearer's application, which is now pending.

Note to Applicant: This medical examination form must be completed by your physician and returned to this office within thirty (30) days from the "Date Issued" indicated below. Failure to comply will result in the suspension of your driving privileges.

☐ **Applicant failed to comply within thirty (30) days.**

1. To be Completed by the Office of Motor Vehicles

This section is to be completed by the Motor Vehicle Analyst at the time this form is issued to the applicant.

Applicant's Name: _____ DOB _____ R/S_____ D/L#_____

Address: _____ City: _____ Zip: _____

Date Issued: _____ MVCA'S Initials: _____ Badge #: _____ Office #: _____

Reason for Issuance: _____

The following sections need to be completed:

■ **History** ☐ **Orthopedic** ☐ **Hearing** ☐ **Cardiopulmonary** ☐ **Neurological** ☐ **Mental** ☐ **Diabetes**

Note to Physician: In accordance with the provisions of R. S. 40:1356, a health care provider is **exempt from any liability** as a result of reporting to the Department of Public Safety and Corrections any visual ability, physical condition, impairment or disability which may impair a person's ability to exercise ordinary and reasonable control in the operation of a motor vehicle. This form must be completed in its entirety by the physician and must reference any illness in the History section as well as why this form was issued. Incomplete forms may be rejected and could result in the denial of this applicant's driving privileges.

2. To be Completed by the Physician (Required)

History

1. Patient's Name: _____ Date of Birth: _____
2. Does patient have any medical or physical disorders? ☐ **Yes** ☐ **No** If yes, list the medical or physical disorders:_____
   _____
3. Is patient taking any medication? ☐ **Yes** ☐ **No** If yes, list current medication and dosage:_____
   _____
4. Has patient had any past surgical procedures? ☐ **Yes** ☐ **No** If yes, list the past surgical procedures:_____
   _____
   _____
5. Has patient had any illness that could affect the ability to operate a motor vehicle safely? ☐ **Yes** ☐ **No**
   If yes, describe the illness: _____
   _____
6. Has patient's driving privileges ever been withdrawn for a medical or physical disorder? ☐ **Yes** ☐ **No**

Orthopedic

1. Does patient have any amputation or skeletal deficits that could interfere with the ability to operate a motor vehicle safely? ☐ **Yes** ☐ **No** If yes, describe the deficits in detail:_____
   _____
2. Does patient have stiff or frail joints? ☐ **Yes** ☐ **No** If yes, describe:_____
   _____
3. Does patient have spastic or paralyzed muscles? ☐ **Yes** ☐ **No** If yes, describe:_____
   _____
4. Does patient have any orthopedic appliances or supports? ☐ **Yes** ☐ **No** If yes, list any device or support and how long used:
   _____
5. Does this device provide adequate compensation for operating a motor vehicle safely? ☐ **Yes** ☐ **No**

Hearing

1. Does the patient have any hearing impairment? ☐ **Yes** ☐ **No**
   If yes, is the patient considered to be deaf or hard of hearing? ☐ **Yes** ☐ **No**
2. Is a hearing aid worn? ☐ **Yes** ☐ **No** If yes, does it give sufficient correction? ☐ **Yes** ☐ **No**

Cardiopulmonary

1. Does patient have angina? ☐ **Yes** ☐ **No** If yes, when does it occur? ☐ Strenuous activity ☐ Normal activity ☐ At rest
2. Does patient have dyspnea? ☐ **Yes** ☐ **No** If yes, when does it occur? ☐ Strenuous activity ☐ Normal activity ☐ At rest
3. Does patient have syncope? ☐ **Yes** ☐ **No** If yes, what is the frequency? Duration:_____Last occurrence:_____
4. Does patient have dizziness? ☐ **Yes** ☐ **No** If yes, describe:_____
   _____
5. What is patient's blood pressure? 1st reading _____ 2nd reading _____
6. What is patient's pulse? Rate _____ Rhythm _____
7. Has patient had cardiovascular catheterization or surgery? ☐ **Yes** ☐ **No** If yes, describe:_____
   _____

List medications and dosage: _____

Neurological

1. Does patient have epilepsy? ☐ **Yes** ☐ **No** If yes, what type of seizures? _____ Date of last seizure? _____
   Are seizures completely controlled? ☐ **Yes** ☐ **No** Is patient under regular medical care? ☐ **Yes** ☐ **No**
   What are the anticonvulsant serum blood levels? _____
2. Does patient have any signs of Parkinsonism? ☐ **Yes** ☐ **No** If yes, describe condition and severity:_____
   _____
   Is coordination normal? ☐ **Yes** ☐ **No** If no, describe:_____
3. Does patient have any neurological disorder? ☐ **Yes** ☐ **No** If yes, describe:_____

List medications and dosage: _____

Is patient reliable in taking medication and following medical regimen? ☐ **Yes** ☐ **No**

Mental

1. Does patient have symptoms of any mental disorder? ☐ **Yes** ☐ **No** If yes, describe condition and severity at present:_____
   _____
2. Has patient ever been treated in a mental hospital? ☐ **Yes** ☐ **No** If yes, where and when:_____
3. What was diagnosis and cure? _____
4. Does patient use alcohol or drugs? ☐ **Yes** ☐ **No** If yes, describe usage:_____
5. Is patient mentally deficient? ☐ **Yes** ☐ **No** If yes, what was highest grade attained in school? _____Age at attainment? _____
6. Does patient have sufficient regard for his/her personal safety as well as that of others to operate a motor vehicle safely?
   ☐ **Yes** ☐ **No** Give details:_____
7. Is patient likely to act on sudden impulse without regard for the consequences of his/her behavior? ☐ **Yes** ☐ **No**
   Give details:_____
8. On the basis of your examination and/or knowledge of this patient, do you recommend periodic psychiatric examinations?
   ☐ **Yes** ☐ **No** Give details:_____

List medications and dosage:_____
_____

Diabetes

1. Does patient have a history of diabetes? ☐ **Yes** ☐ **No** If yes, is insulin taken? ☐ **Yes** ☐ **No**
   Is oral medication taken? ☐ **Yes** ☐ **No**
2. What are patient's laboratory studies? Recent urine sugars: _____ Recent blood sugars:_____
3. Has patient had any occurrences of diabetic coma? ☐ **Yes** ☐ **No** If yes, give dates:_____
4. Has patient had any occurrences of insulin shock? ☐ **Yes** ☐ **No** If yes, give dates:_____
5. Does patient have associated abnormalities? ☐ Visual ☐ Renal ☐ Vascular ☐ Neurological ☐ Other_____
   If yes, describe:_____
6. Does patient have hypoglycemia? ☐ **Yes** ☐ **No** If yes, describe treatment:_____

List medications taken and dosage: _____

7. Is patient reliable in taking diabetes medication? ☐ **Yes** ☐ **No** Is diabetes controlled? ☐ **Yes** ☐ **No**

3. To be Signed by the Patient (Required)

I hereby authorize the examining physician whose signature appears below to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

Date: _____ Signature of Patient: _____

4. To be Completed, Signed, and Dated by the Physician (Required)

Please refer to the "Note to Physician" on the first page of this form. **This form is considered valid only if the date of the physician's signature has not exceeded sixty (60) days.**

Are you this patient's treating physician?

☐ **Yes** ☐ **No**

In your opinion, from a medical standpoint, is it safe for this patient to operate a motor vehicle?

☐ **Yes** ☐ **No**

On the basis of your examination and/or knowledge of this patient, do you recommend periodic medical reports be submitted?

☐ **Yes** ☐ **No** If yes, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ Other:_____

Remarks: _____

_____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Telephone #: _____

Physician's Address: _____