



Louisiana Department of Public Safety and Corrections
 Office of Motor Vehicles
 PO Box 64886, Baton Rouge, LA 70896-4886
Medical Examination Form DPSMV2302 (R 05/2022)

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the medical or physical disorders: _____
	3. Is patient taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list current medication and dosage: _____
	4. Has patient had any past surgical procedures? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the illness: _____
	6. Has patient's driving privileges ever been withdrawn for a medical or physical disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic	1. Does patient have any amputation or skeletal deficits that could interfere with the ability to operate a motor vehicle safely? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the deficits in detail: _____
	2. Does patient have stiff or frail joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____
	3. Does patient have spastic or paralyzed muscles? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____
	4. Does patient have any orthopedic appliances or supports? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No

Hearing	<p>1. Does the patient have any hearing impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient considered to be deaf or hard of hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is a hearing aid worn? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does it give sufficient correction? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Cardiopulmonary	<p>1. Does patient have angina? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when does it occur? <input type="checkbox"/> Strenuous activity <input type="checkbox"/> Normal activity <input type="checkbox"/> At rest</p> <p>2. Does patient have dyspnea? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when does it occur? <input type="checkbox"/> Strenuous activity <input type="checkbox"/> Normal activity <input type="checkbox"/> At rest</p> <p>3. Does patient have syncope? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the frequency? Duration: _____ Last occurrence: _____</p> <p>4. Does patient have dizziness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____</p> <p>5. What is patient's blood pressure? 1st reading _____ 2nd reading _____</p> <p>6. What is patient's pulse? Rate _____ Rhythm _____</p> <p>7. Has patient had cardiovascular catheterization or surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____</p> <p>List medications and dosage: _____</p>
Neurological	<p>1. Does patient have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type of seizures? _____ Date of last seizure? _____ Are seizures completely controlled? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient under regular medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No What are the anticonvulsant serum blood levels? _____</p> <p>2. Does patient have any signs of Parkinsonism? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe condition and severity: _____</p> <p>Is coordination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe: _____</p> <p>3. Does patient have any neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____</p> <p>List medications and dosage: _____</p> <p>Is patient reliable in taking medication and following medical regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Mental	<p>1. Does patient have symptoms of any mental disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe condition and severity at present: _____</p> <p>2. Has patient ever been treated in a mental hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where and when: _____</p> <p>3. What was diagnosis and cure? _____</p> <p>4. Does patient use alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe usage: _____</p> <p>5. Is patient mentally deficient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was highest grade attained in school? _____ Age at attainment? _____</p> <p>6. Does patient have sufficient regard for his/her personal safety as well as that of others to operate a motor vehicle safely? <input type="checkbox"/> Yes <input type="checkbox"/> No Give details: _____</p> <p>7. Is patient likely to act on sudden impulse without regard for the consequences of his/her behavior? <input type="checkbox"/> Yes <input type="checkbox"/> No Give details: _____</p> <p>8. On the basis of your examination and/or knowledge of this patient, do you recommend periodic psychiatric examinations? <input type="checkbox"/> Yes <input type="checkbox"/> No Give details: _____</p> <p>List medications and dosage: _____</p>
Diabetes	<p>1. Does patient have a history of diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is insulin taken? <input type="checkbox"/> Yes <input type="checkbox"/> No Is oral medication taken? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. What are patient's laboratory studies? Recent urine sugars: _____ Recent blood sugars: _____</p> <p>3. Has patient had any occurrences of diabetic coma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give dates: _____</p> <p>4. Has patient had any occurrences of insulin shock? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give dates: _____</p> <p>5. Does patient have associated abnormalities? <input type="checkbox"/> Visual <input type="checkbox"/> Renal <input type="checkbox"/> Vascular <input type="checkbox"/> Neurological <input type="checkbox"/> Other _____ If yes, describe: _____</p> <p>6. Does patient have hypoglycemia? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe treatment: _____</p> <p>List medications taken and dosage: _____</p> <p>7. Is patient reliable in taking diabetes medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Is diabetes controlled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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.

Are you this patient's treating physician?

Yes No

In your opinion, from a medical/vision 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/vision 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: _____