



Louisiana Department of Public Safety and Corrections
Office of Motor Vehicles
Medical Examiner's Certification of Autism Spectrum Disorder

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

1. TO BE COMPLETED BY THE APPLICANT

Applicant's Name: _____		Date of Birth: _____	
Race: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Credential # _____	
Address: _____		City: _____	Zip: _____

2. TO BE COMPLETED BY THE LICENSED MEDICAL PROFESSIONAL

I certify that _____ has been diagnosed with autism spectrum disorder and meets the requirements for the autism designation, as defined in R.S. 32:412 (P).		
_____	_____	_____
Medical Professional's Signature	Date	Address
_____	_____	_____
Medical Professional's Printed Name	City, State, Zip	
_____	_____	_____
Medical Professional's Title	License #	Telephone Number

3. TO BE COMPLETED BY THE OFFICE OF MOTOR VEHICLES

_____	_____	_____	_____
Date	MVCA's Initials	Badge #	Office #