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: ☐ Male ☐ 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 #