LOUISIANA DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS
OFFICE OF MOTOR VEHICLES

PHYSICIAN'S CERTIFICATION FOR SEAT BELT EXEMPTION

I certify that (Name) _____ Birth Date: _____

(Address) _____ Race/Sex: _____

_____ Driver's License #: _____

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 _____.
(date) (date)

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

_____ _____
Physician's Signature Date

_____ _____
Street Address Telephone #

_____
City, State, Zip

TO BE COMPLETED BY MV OFFICER ONLY

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

DPSMV 2012 (R 03/09)