

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: _____

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 _____ (date) through _____ (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 _____