Please print information legibly. Forms with illegible writing may be returned and cause delays in applications for Concealed Handgun Permits or Special Officer Commissions (SOC).

Date: _____

RE: Name: _____

Date of Birth: _____

Social Security Number: _____

Permit # (or SOC #): _____

Dear Physician,

The individual referenced above has applied with the Department of Public Safety and Corrections for either a Louisiana Concealed Handgun Permit or an SOC. The applicant has informed the Department that he/she has received treatment and/or prescribed medication from you.

Louisiana Law requires an investigation into the applicants' legal qualifications. To qualify for a permit an applicant must: not suffer from a mental infirmity due to disease, illness, or retardation which prevents the safe handling of a handgun; not be an unlawful user of, or addicted to, marijuana, depressants, stimulants, or narcotic drugs; not have been committed, either voluntarily or involuntarily, for the abuse of a controlled dangerous substance; not have been adjudicated to be mentally deficient or been committed to a mental institution.

Please complete the Medical Disposition Questionnaire, so that the Department can evaluate the referenced applicant's qualifications.

Your assistance is greatly appreciated. Should you have any questions, please contact the Concealed Handgun Permit Unit at (225) 925-4867. Any correspondence to be returned to the Concealed Handgun Permit Unit should be mailed to the following address:

Louisiana State Police
Concealed Handgun Permit Unit
P.O. Box 66375
Baton Rouge, LA 70896

Louisiana State Police
Concealed Handgun Permit Unit
P.O. Box 66375
Baton Rouge, LA 70896
(225) 925-4867

Patient's Name: _____

Date of First Contact: _____ Length of Treatment: _____ (Indicated Date)

Why was treatment sought?

_____

_____

_____

Condition described to Physician:

_____

_____

_____

Specific Conditions for which treatment has been sought:

_____

_____

_____

Diagnosis:

_____

_____

_____

Medication prescribed: (Indicate dosage amount and directions given to patient)

_____

_____

_____

Indicate effects of medication: (such as drowsiness, etc.)

_____

_____

_____

In your professional opinion could the medication(s) prescribed cause any impairment in judgment or motor skills? _____ (If "Yes" please explain)

_____

_____

_____

In your professional opinion does the patient's condition for which he/she has sought treatment reach the level of physical or mental/judgment impairment, which could prevent them from the safe handling of a handgun? _____ (If "Yes" please give details)

_____

_____

_____

In your professional opinion, does the patient's condition for which he/she has sought treatment pose any threat or risk of injury to themselves or others? _____ (If "Yes" please give details)

_____

_____

_____

Response to treatment:

_____

_____

_____

Release Date: (If Applicable) _____

Additional recommendations, information, or comments:

_____

_____

_____

_____ _____

(Physician's Printed Name) **(Office Telephone Number)**

_____ _____

(Physician's Signature) **(Date)**

_____

(MD/DO#)