

Date: \_\_\_\_\_

RE: Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Gun Permit #: \_\_\_\_\_

Dear Physician:

The individual referenced above has applied with the Department of Public Safety and Corrections for a Louisiana concealed handgun permit. 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

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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?

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Condition described to Physician:

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Specific Conditions for which treatment has been sought:

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Diagnosis:

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

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

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

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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.)

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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.)

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Response to treatment:

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Release Date: (If Applicable) \_\_\_\_\_

Additional recommendations, information, or comments:

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\_\_\_\_\_  
**(Physician's Printed Name)**

\_\_\_\_\_  
**(Office Telephone Number)**

\_\_\_\_\_  
**(Physician's Signature)**

\_\_\_\_\_  
**(Date)**