MVD-10125
REV. 05/04

State of New Mexico - Motor Vehicle Division

**DIVISION USE ONLY**

License Type Issued: ❑ Permit ❑ Regular ❑ Commercial

Field Office No. _____

# VISUAL/OCULAR REPORT

**MOTOR VEHICLE DIVISION**
**Drivers Services Bureau**
**P.O. Box 1028, Santa Fe, NM 87504-1028**

Medical Advisory Board
❑ APPROVED
❑ DENIED

Please be advised that the decision to allow applicant to continue to retain his/her New Mexico driver's license is contingent upon the information provided in this medical report. It is imperative, and in the best interest of the applicant and the motoring public, that all questions be answered and that the dates and results of any and all medical examinations be provided. This report will be reviewed by a panel of physicians, become part of the applicant's record, is for the confidential use of the board or the division and may not be divulged to any person or used as evidence in any trial.

## ALL INFORMATION MUST BE TYPED OR PRINTED

| Applicant's Name (Last, First, Middle Initial) | Date of Birth |
|---|---|
| | |

| Mailing Address | City, State, Zip Code |
|---|---|
| | |

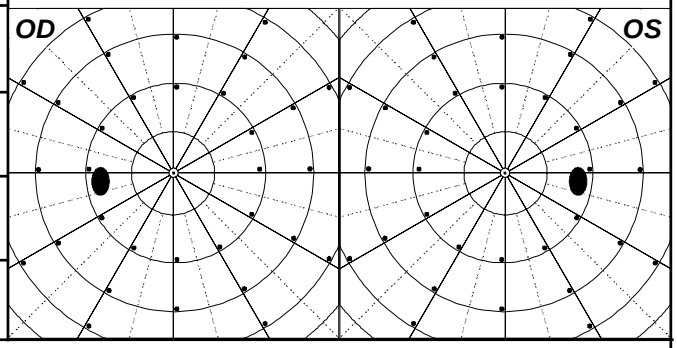
| Social Security Number | Driver License Number |
|---|---|
| | |

1. GIVE DATE OF LAST EXAMINATION

| 2. VISUAL ACUITY | O. D. | O. S. | O. U. |
|---|---|---|---|
| WITHOUT GLASSES | | | |
| WITH GLASSES OR CONTACT LENSES. ***STATE*** *WHICH/BOTH* | | | |

4. DIPLOPIA ❑ ABSENT ❑ PRESENT — IF PRESENT, IS IT CORRECTED? ❑ YES ❑ NO

3. VISUAL FIELDS - ? FULL — If not normal, indicate below




5. DESCRIBE CONDITIONS IMPAIRING PATIENT'S VISION:

6. ARE ANY OF THE PATIENT'S VISION DEFECTS/DISABILITIES PROGRESSIVE? ❑ YES ❑ NO

7. DRIVING HAZARD? ❑ YES ❑ NO

8. LIST MEDICATIONS:

9. INDICATE YOUR RECOMMENDED LENGTH FOR THE INTERVAL TO THE NEXT LICENSE RENEWAL DATE:

❑ 4 YEARS ❑ 1 YEAR ❑ DENY

RECOMMENDATIONS:

10. RESTRICTIONS

❑ CORRECTIVE LENSES ❑ DAYLIGHT HOURS ❑ LOCAL AREA

| Ophthalmologist's (MD) or Optometrist's (OD) Name | Office Telephone Number |
|---|---|
| | |

| Office Address | City, State, Zip Code |
|---|---|
| | |

| Ophthalmologist's or Optometrist's Signature | Date Signed<br>Physician License Number |
|---|---|
| | |