



**DIVISION USE ONLY**

License  Permit  
 Type  Regular  
 Issued:  Commercial

Field Office No. \_\_\_\_\_

# VISUAL/OCULAR REPORT

**MOTORVEHICLE 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			3. VISUAL FIELDS - ? FULL <span style="float:right">If not normal, indicate below</span>	
2. VISUAL ACUITY	O. D.	O. S.	O. U.	
	WITHOUT GLASSES			
WITH GLASSES OR CONTACT LENSES. STATE WHICH/BOTH				
4. DIPLOPIA	<input type="checkbox"/> ABSENT <input type="checkbox"/> PRESENT	IF PRESENT, IS IT CORRECTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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: <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 1 YEAR <input type="checkbox"/> DENY	RECOMMENDATIONS:
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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 Physician License Number