

NEW MEXICO TAXATION & REVENUE DEPARTMENT, MOTOR VEHICLE DIVISION



VISION REPORT

Please be advises that the decision to allow an applicant to continue to retain his/her driver's license is contingent

upon the information provided in this medical report. It is imperative that all questions be answered completely. This form will become part of the applicant's record. It is for confidential use of the physician or division and may be divulged to any person or used as evidence in any trial. ALL INFORMATION MUST BE TYPED OR CLEARLY PRINTED **Applicant Information** Applicant's Name (Last, First, Middle Initial) Date of Birth Mailing Address City, State ZIP Code E-mail Address Area Code + Telephone Number Social Security Number NM Driver's License Number 1. Give date of last examination 3. Visual Fields - Full? If not normal, indicate below. OD 2. VISUALACUITY 0.S. 0.D. 0.U. Without glasses With glasses or contact lenses (state which/both) If present, is it corrected? 4. DIPLOPIA Describe conditions impairing patient's vision. 6. Are any of the patient's vision defects/disabilities progressive? ☐ Yes □ No 7. List the kind, quantity and frequency of any medication with which the patient is being treated.

Last name, First name, & DOB			
8. From a medical standpoint only, is the patient capable of safe and competent driving? U Yes U No -DENIAL - do not issue driver's license			
9. Recommended restrictions for Driving:			
□ Corrective lenses □ Daylight hours □ None			
10. Recommended renewal interval:			
1 year 2 years 8 years		☐ 3 years	4 years
Physician's name (print clearly)		Office telephone numbe	er
Office Street Address	City, State ZIP Code		
Physician's Signature	Date Signed	Physicians License	e Number
Vision Report Form - Instructions for Physicians			
The final decision to accept or deny an application is the responsibility of the MVD. Physicians are asked to type or print all information carefully and legibly, to complete every section, and to follow these instructions when completing the Medical Report form: • Applicant Information: Please start with the applicant's LAST NAME and print all information neatly. Complete all items, including Social Security Number (SSN). The SSN is confidential and will NOT be printed on the driver's license or permit. • Physician's Report: #5 Describe ALL diseases or conditions that apply and could affect the patient's ability to drive safely and competently. Do NOT include diagnoses if they do not actually affect the applicant's ability to drive safely. Be sure to indicate treatment details, including dosage and level of control. Continue on another sheet of paper if necessary. #6 Indicate by checking yes or no whether the disease or condition is progressive. #8 If the applicant is NOT capable of driving safely, please explain, continuing on the reverse or on a separate sheet of paper. #9 Specify any driving restrictions that are appropriate based on the patient's disease or vision condition. #10 Indicate the recommended renewal period for the next issuance of driver's license base on the patient's disease, vision condition and reevaluation.			
 Physician's name, contact information, signature, date and license number: Please complete ALL sections NEATLY. There are several ways to Return completed form to MVD Drivers Services Bureau: Please select one of the following: Mail the Vision Report document to: Attn: Driver's Bureau Motor Vehicle Division PO Box 1028 Santa Fe, NM 87504-1028 Upload the Vision Report document to: MVDOnline.com>Eservices>Forms> Submit Medical Documentation or Schedule an appointment at your pagest MVD office 			
 Schedule an appointment at your nearest MVD office State office appointments at MVDOnline.com 			