MVD - 11095
REV. 03/98

STATE OF NEW MEXICO - MOTOR VEHICLE DIVISION

MEDICAL REPORT ON APPLICANT
Requesting Waiver to Drive Commercial Vehicle

Please have this form completed by a physican and mail to:
(or deliver to any New Mexico Motor Vehicle Field Office)

Motor Vehicle Division
Drivers Services Bureau
P.O. Box 1028
Santa Fe, NM 87504-1028

Please be advised that the decision to allow applicant to drive a commercial vehicle within the State of New Mexico 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.

INSTRUCTIONS: PLEASE TYPE OR PRINT ALL INFORMATION

Practitioner must complete Sections I, 2 AND 4 for Medical Waiver Applicants with Vision Deficiencies.

Physicians must complete Sections 2, 3 AND 4 for Medical Waiver Applicants with Medical Problems.

Patient's Name (Last, First, Middle Initial)	Date of Birth	Social Security Number

Address	City, State, Zip Code

Class of License	Vehicle Type	GVWR

FIELD OFFICE EYE TEST RESULTS: ❑ Without glasses ❑ With Glasses

RIGHT 20 / LEFT 20 / BOTH 20 /

Date

Examiner

SECTION 1

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

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

3. DIPLOPIA ❑ ABSENT ❑ PRESENT

IF PRESENT, IS IT CORRECTED? ❑ YES ❑ NO

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

5. DESCRIBE CONDITIONS IMPAIRING PATIENT'S VISION:

SECTION 2

1. LIST MEDICATIONS AND DOSAGE PATIENT IS RECEIVING:

2. DO ANY OF THESE MEDICATIONS IMPAIR PATIENT'S ABILITY TO OPERATE A MOTOR VEHICLE SAFELY? IF YES, IN WHAT MANNER?

3. FROM A *MEDICAL STANDPOINT ONLY*, IS THE PATIENT CAPABLE OF SAFE AND COMPETENT DRIVING? ❑ YES ❑ NO

Recommended Restrictions:

SECTION 3

PATIENT'S DISEASE(S) OR CONDITION(S)

❑ NEUROLOGICAL ❑ CARDIOVASCULAR ❑ HYPOGLYCEMIA
❑ PSYCHOLOGICAL ❑ EPILEPSY ❑ DIABETES
❑ OTHER: _____

1. How long have you been treating the Patient?

2. Give frequency of office visits.

3. Describe the nature, extent and frequency of any of the patient's signs or symptoms, especially those that might affect the safe operation of a motor vehicle.

4. What is your diagnosis and method of treatment?

5. What was the Patient's age at onset? Give any known cause(s).

6. If applicable, give date(s) of last EKG, EEG or other relevant test (specify), name of physician(s) performing test(s) and results.

7. Date of last blood pressure test and results:

8. If applicable, list any abnormal personality traits, addictions, etc.

9. Do you consider the patient's condition or complications controlled?

SECTION 4

Physician or Practioners Name	Degree
Office Address	Office Phone
City, State, Zip Code	
Physican or Practioners Signature	DATE

MEDICAL ADVISORY BOARD RECOMMENDATION

WAIVER GRANTED

❑ YES ❑ NO

With Restriction(s):

MVD CENTRAL OFFICE USE ONLY

WAIVER GRANTED

❑ YES ❑ NO

_____ _____

Signature of MVD Director or Authorized Agent Date