

State of New Mexico
MOTOR VEHICLE DIVISION



MEDICAL REPORT

DIVISION USE ONLY

Field Office Number _____

What was issued?

- License
 Permit

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.

Please have this form completed by a physician and mail to: Motor Vehicle Division
(or deliver to any New Mexico Motor Vehicle Field Office) Drivers Services Bureau
P.O. Box 1028
Santa Fe, NM 87504-1028

- PLEASE TYPE OR PRINT ALL INFORMATION -

Patient's Name (Last, First, Middle Initial) _____

Date of Birth	Social Security Number	Driver License Number
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Address	City, State, Zip Code
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TYPE OF DISEASE(S) OR CONDITION(S) PATIENT IS BEING TREATED FOR:

NEUROLOGICAL CARDIOVASCULAR HYPOGLYCEMIA LAPSES OF CONSCIOUSNESS
 PSYCHOLOGICAL EPILEPSY DIABETES ORTHOPEDIC
 OTHER: _____

1. How long have you been treating the Patient? _____

2. Give frequency of office visits and date of last examination: _____

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. List kind, quantity and frequency of any medication the patient is being treated with.

9. Does medication impair the patient's ability to safely operate a motor vehicle? If yes, briefly explain effect(s).

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

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

12. From a medical standpoint only, is the patient capable of safe and competent driving?

YES NO

Recommended Restrictions:

13. For driver licensing purposes, indicate next recommended interval for medical report review:

_____ YEARS AND/OR _____ MONTHS

Physician's Name (*Please Print or Type*)

Office phone

Office Address

City, State, Zip Code

Physician's Signature

Date