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| 11 Calle 15-62 Zona 13 | | **INTEVISA** |  |  | logocompleto |
|  |  | CERTIFICADO |  | |
|  | DE EXAMEN DE LA VISTA – AGUDEZA VISUAL – | | | |
| Este certificado tiene validez por 6 meses a partir de la fecha de su emisión. No debe llevar tachones, borrones ni correcciones. | | | | | |
| *EL PRESENTE FORMULARIO DEBERIA SER LLENADO UNICAMENTE A MÁQUINA DE ESCRIBIR O COMPUTADORA* | | | | | |
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|  | **DATOS DEL PROFESIONAL** | |  |  |
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| NUMERO DE REGISTRO EN EL DEPARTAMENTO DE TRANSITO | |  |  |
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| NUMERO DE REGISTRO EN EL MINISTERIO DE SALUD | |  |  |
|  | | | |
| NUMERO DE REGISTRO EN LA ASOCIACION GUATEMALTECA DE OFTALMOLOGIA | |  |  |

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|  | **CERTIFICA QUE** | | | | | | | | |  |  |
| NOMBRE COMPLETO DEL PACIENTE: | |  | | | | | | | |  |  |
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| DPI, CÉD. DE VECINDAD O PARTIDA DE NACIMIENTO: | | | | | | | | | |  |
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| FECHA DE NACIMIENTO |  | | | SEXO | | | | | |  |
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| DEPARTAMENTO |  | | MUNICIPIO | | | | | | |  |
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| RESIDENCIA DOMICILIAR (DIRECCIÓN EXACTA) | | | | | | | | | |  |
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**Obtuvo los siguientes RESULTADOS CLINICOS del examen de Agudeza Visual:**

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| ***AGUDEZA VISUAL*** | | | | |
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| ***VISION DE COLORES*** | | |  | ***SENSIBILIDAD DE CONTRASTES*** | | |
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| Normal |  | Deficiente | Normal |  | Deficiente |

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| ***CAMPO VISUAL CENTRAL EN GRADOS*** | | | | |  | ***CAMPO VISUAL PERIFERICO EN GRADOS*** | | | | |
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| O.D. |  |  | O.I. |  | O.D |  |  | O.I. |  |
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| Normal | |  | Deficiente | | Normal | |  | Deficiente | |

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| ***PRUEBA ESTEREOSCOPIA PARA VISION LEJANA*** | | |  | ***>= A 600 SEG*** | | |
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| Si hay estereopsis |  | No hay estereopsis | Si |  | No |

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| ***USA ANTEOJOS*** | | |  | ***USA LENTES DE CONTACTO*** | | |
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| Si |  | No | Si |  | No |

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| En base a los parámetros de visión autorizados por el Departamento de Transito, el paciente se encontró apto para obtener licencia de conducir: | | | | | | | | | | | | |
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