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| **Señores**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Instituto Nacional de Medicina legal** |  |  | **Centro Médico** |  |  | **Cuál:** |  |  |  |  |  | | --- | --- | --- | --- | | Nombres y Apellidos | | Identificación | Edad | |  | |  |  | | Dirección | Barrio | Municipio/Localidad | Teléfono | |  |  |  |  |  |  |  | | --- | --- | | **Aspectos a Valorar (señale con una X)** | | |  | | |  | **Lesiones Personales**: Descripción de aquellas, instrumento con el que fueron causadas, determinación de la incapacidad y secuelas que se generen. Si se sugieren exámenes específicos y demás que considere importante, indíquelo en su informe pericial.  Se anexa resumen o copia de Historia Clínica SI ( ) NO ( )  Presunta responsabilidad médica: SI ( ) NO ( ) (anexar cuestionario) | |  | **Valoración de Embriaguez u otras sustancias.** Descripción del estado de la persona si se encuentra bajo influjo de bebida embriagante o de droga o sustancia que produzca dependencia física o síquica, Grado de la misma, exploración practicada. Si se sugieren exámenes específicos y demás que considere importante, indíquelo en su informe pericial  Alcoholemia: SI ( ) NO ( )  Otras sustancias: SI ( ) NO ( ) Cuáles: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Entidad solicitante | | | | | | | | Unidad | Secretaria de Movilidad de Fusagasugá | | | | Despacho |  | | Dirección | Calle 3 Bis # 27-00 Pueblito Fusagasugueño | | | | Teléfono |  | | Departamento | | | Cundinamarca | | Municipio | Fusagasugá | | Nombre |  | | | | Cargo | Agente de Transito | | Correo electrónico | | agentetransito@fusagasugacundinamarca.gov.co | | | Firma |  | |  | | | | | | | | Firma de quien recibe | | | |  | | | | Nombre y apellidos | | | |  | | | | Identificación | | | |  | | | | Teléfono | | | |  | | | | Cargo | | | |  | | | | Fecha y hora | | | |  | | | | Correo electrónico | | | |  | | | |