

NOTICE

IF RENEWING: YOU MAY RECEIVE YOUR VISION TEST FREE OF CHARGE AT THE DRIVER LICENSE EXAMINING STATION. If you fail to test 20/40 in at least one eye at the examining station, you will be required to take THIS FORM to a vision specialist. If you fail to test 20/60 in at least one eye by the vision specialist, your report may be forwarded, by the Examiner, to the DIVISION OF VEHICLES. Recent exam required (within past ninety (90) days).

FOR ANNUAL REVIEWS: Please have this form completed by your eye specialist. Return completed form, within sixty (60) days, to the DIRECTOR OF VEHICLES for review and recommendations regarding your driving privileges. Recent exam required (Within past ninety (90) days).

INSTRUCTIONS FOR LICENSED OPTOMETRIST/OPHTHALMOLOGIST

Please sign this report after completing the questions on the form below. No recommendations or suggestions as to which specialist to visit are given by the Driver License Examiners. The eye specialist assumes no responsibility in making this report other than that of truthfully representing the facts as they appear in his/her professional judgement.

NAME OF APPLICANT: _____ DL#: _____
Last First Middle

APPLICANT ADDRESS: _____ DOB: _____

APPLICANT'S SIGNATURE _____

VISION FORM TO BE COMPLETED BY OPTOMETRIST OR OPTHALMOLOGIST

<u>ACUITY</u>	<u>RIGHT EYE</u>	<u>LEFT EYE</u>	<u>BOTH EYES</u>	<u>FIELD OF VISION</u>
PRESENT LENSES	20/	20/	20/	RT OF FIXATION:
WITHOUT LENSES	20/	20/	20/	LT OF FIXATION:
BEST CORRECTION	20/	20/	20/	TOTAL ANGLE:
BIOPTIC/TELESCOPIC	20/	20/		

(If prescribed for driving)

DO PRESENT, REG. LENSES PROVIDE FOR BEST POSSIBLE CORRECTION? YES _____ NO _____

ARE NEW REGULAR LENSES BEING PRESCRIBED? YES _____ NO _____

HAVE THEY BEEN FITTED? YES _____ NO _____

DIAGNOSIS OF VISUAL CONDITION: _____

I BELIEVE THIS PERSON CAN SAFELY OPERATE A MOTOR VEHICLE AT THIS TIME INSOFAR AS THIS PERSON'S VISION IS CONCERNED.

(This question may be omitted if visual acuity is better than 20/60 in at least one eye. Applicant must also meet all other qualifications required for issuance of a driver's license as determined by the Driver's License Examiner or the Director of Vehicles.)

YES _____ NO _____

AN ANNUAL VISION REPORT SHOULD BE REQUIRED: YES _____ NO _____

Applicant's physical/medical/mental condition should be evaluated: YES _____ NO _____

INDICATE BELOW WHICH RESTRICTIONS MAY APPLY TO PATIENT'S LICENSE IF ISSUED OR CONTINUED.

Maximum: Four (4) restrictions

- | | |
|--------------------------------|--|
| 1. _____ CORRECTIVE LENSES | 5. _____ WITHIN CITY LIMITS |
| 2. _____ DAYLIGHTS HOURS ONLY | 6. _____ LICENSED DRIVER FRONT SEAT |
| 3. _____ NO INTERSTATE DRIVING | 7. _____ DRIVING WITHIN A _____ MILE RADIUS OF HOME
(5-30 miles in 5 mile increments) |
| 4. _____ OUTSIDE BUSINESS AREA | 8. _____ OUTSIDE MIRROR |

Name of Optometrist/Ophthalmologist

(Please print) DATE OF EXAMINATION

Address

Phone

Signature of Optometrist/Ophthalmologist

DATE SIGNED

DE-44

Rev. (07/01)