PLEASE RETURN COMPLETED VISION FORM TO:

STATE OF KANSAS DIRECTOR OF VEHICLES
MEDICAL/VISION UNIT
300 SW 29th STREET
PO BOX 2188
TOPEKA KS 66611

PH: Telephone: (785) 368-8971
FAX: FAX: (785) 296-5857

KANSAS DIVISION OF VEHICLES VISION FORM

GENERAL INFORMATION & HISTORY – TO BE FILLED OUT BY THE PATIENT

NAME: _____ DRIVER LICENSE #:_____DOB: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE #: _____

Currently enrolled in Driver's Education? YES / NO If yes, instructor name & phone number: _____

RELEASE OF INFORMATION

Permission is granted for release of all vision information concerning me to the Kansas Division of Vehicles by all medical professionals filling out this form.

_____ _____
SIGNATURE OF PATIENT DATE

To the Vision Professionals: You assume no responsibility in making this report other than that of truthfully representing the facts as they appear in your professional judgment. **The information on this form must be from an examination within the last 90 days.**

Instructions:

1. Please answer each question and fill out the entire form carefully and legibly.
2. Indicate yes or no whether from a visual standpoint only, this patient is capable of safely operating a motor vehicle.
3. Specify any driving restrictions that are appropriate based on the patient's vision condition.

If you have any questions please call (785)368-8971.

SECTION I: VISION REPORT

	Acuity Right Eye	Acuity Left Eye
Visual Acuity without Glasses	20/_____	20_____
Visual Acuity with Glasses	20/_____	20_____
Best Correction	20/_____	20_____
Bioptic/Telescopic (for vision specialist use only)	20/_____	20_____

Horizontal Field of Vision

Equal to or greater than 20°?
☐ Yes ☐ No

Does this patient require a drive test? ☐ Yes ☐ No
This patient is capable of safely operating a motor vehicle. (Driver must be considered a safe candidate in order to request a drive test.) ☐ Yes ☐ No
An annual vision report should be required. ☐ Yes ☐ No
Does this patient require a medical exam? ☐ Yes ☐ No

Indicate below which restrictions may apply to the patient's license if issued or continued: Maximum 6 restrictions.

☐ Corrective Lenses ☐ Daylight Hours Only ☐ No Interstate Driving ☐ Outside Business Area
☐ Within City Limits ☐ Licensed Driver in Front Seat ☐ Automatic Transmission ☐ Outside Mirror
☐ Mechanical Aid ☐ Prosthetic Aid ☐ _____Miles From Home (5-30 in 5 mile increments)

_____ _____
Name of Optometrist/Ophthalmologist (Please print) Date of Examination

_____ _____
Address Signature of Optometrist/Ophthalmologist

_____ _____
Phone Date Signed