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/OPTHALMOLOGIST

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 OPHTHALMOLOGIST

ACUITY	RIGHT EYE	LEFT EYE	BOTH EYES	FIELD OF VISION
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 (If prescribed for driving)	20/	20/		

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