

**APPLICANT COMPLETES THIS SECTION**

**INSTRUCTIONS:** Please complete the driver license number, date of birth, telephone number, name, and address areas of this form. **You must sign and date the authorization line.** All medical information received by the Department of Motor Vehicles (DMV) is confidential under California Vehicle Code (CVC) Section 1808.5. Please bring this completed form and any new corrective lenses with you when you return to DMV for further testing. If any section of this form is incomplete, it may have to be returned to the vision specialist for completion. **DO NOT MAIL THIS FORM BACK TO DMV** unless asked to do so by a DMV employee. **Alterations or erased information may void this form.**

Your vision specialist should conduct a new vision examination unless one has been conducted within the last six months. **DMV will make the final licensing decision based on a combination of factors, including information from your vision specialist.**

DRIVER LICENSE NUMBER	DATE OF BIRTH (MO., DAY, YR.)	HOME TELEPHONE NUMBER
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NAME (FIRST, MIDDLE, LAST) \_\_\_\_\_

RESIDENCE ADDRESS	CITY	STATE	ZIP CODE
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*I authorize the vision specialist conducting this examination to provide the Department of Motor Vehicles with the following information for its confidential use (CVC §1808.5) in evaluating my ability to safely operate a motor vehicle.*

APPLICANT'S SIGNATURE	DATE
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DMV's Visual Acuity Screening Standard is:

- 20/40 with both eyes tested together, **and**
- 20/40 in one eye, **and**
- 20/70, at least, in the other eye.

**OPHTHALMOLOGIST OR OPTOMETRIST COMPLETES THOSE SECTIONS THAT APPLY — Information must be from exam within last 6 months.**

**1. REFRACTION — Complete only those sections that apply.**

HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses	DATE NEW LENSES WERE PRESCRIBED _____	IS NIGHT DRIVING RECOMMENDED? <input type="checkbox"/> Yes <input type="checkbox"/> No
IS MONOVISION EMPLOYED? By contact lenses <input type="checkbox"/> Yes <input type="checkbox"/> No By refractive surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Is best corrected visual acuity in each eye recommended for driving? <input type="checkbox"/> Yes <input type="checkbox"/> No	DID YOUR PATIENT RECEIVE BIOPTIC LENS TRAINING? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known	DID PATIENT RECEIVE BIOPTIC LENS TRAINING THAT INCLUDED DRIVING? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known
Bioptic Telescope <input type="checkbox"/> Right eye 20/ _____ <input type="checkbox"/> Left eye 20/ _____ Bioptic Telescope suitable for driving? <input type="checkbox"/> Yes <input type="checkbox"/> No	SKILL IN USING BIOPTIC TELESCOPE <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Not Known	

**2. VISUAL ACUITY — Complete Clinical Measurement Section. Lenses include contact lenses or glasses.**

	DMV MEASUREMENT (FOR DMV USE ONLY)			CLINICAL MEASUREMENT (WITHOUT BIOPTIC TELESCOPE)		
	Both Eyes	Right Eye	Left Eye	Both Eyes	Right Eye	Left Eye
Without Lenses	20/	20/	20/	Without Lenses	20/	20/
With Current Lenses	20/	20/	20/	With Lenses	20/	20/
				Best Corrected Visual Acuity	20/	20/

**3. DIAGNOSIS —** Please indicate vision condition by checking the box(es) representing affected eye(s). If the diagnosed condition is not listed, write the diagnosis under "other diagnosis/comments" below.

<b>REFRACTIVE</b>	<b>R</b>	<b>L</b>	<b>DEVELOPMENTAL</b>	<b>R</b>	<b>L</b>	<b>OPTICAL</b>	<b>R</b>	<b>L</b>	<b>RETINAL/OPTIC NERVE</b>	<b>R</b>	<b>L</b>	<b>VISUAL FIELDS</b>	<b>R</b>	<b>L</b>
Astigmatism	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Peripheral Vision	<input type="checkbox"/>	<input type="checkbox"/>
Hyperopia	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	Corneal Opacity	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Hemianopia	<input type="checkbox"/>	<input type="checkbox"/>
Myopia	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Nystagmus	<input type="checkbox"/>	<input type="checkbox"/>	Diplopia (uncorrectable)	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Quadrantanopia	<input type="checkbox"/>	<input type="checkbox"/>
			Albinism	<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Peripheral Vision. Please identify the areas affected on the chart in Section 5 (see reverse).		
						Aphakia	<input type="checkbox"/>	<input type="checkbox"/>	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>			
						Pseudophakia	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Damage	<input type="checkbox"/>	<input type="checkbox"/>			
						Post. Caps. Opac.	<input type="checkbox"/>	<input type="checkbox"/>	(CRVO, PRP etc.)					

Other diagnosis/comments \_\_\_\_\_

Monocular Vision (No Light Perception or Prosthesis) If monocular, when was the monocular vision diagnosed? \_\_\_\_\_

If monocular, does the patient have a medical condition that could affect the functional eye in the future?  Yes  No

Any eye surgery (including refractive)?  Yes  No Date of most recent surgery \_\_\_\_\_ Type of surgery \_\_\_\_\_

**4. PROGNOSIS**

Diagnosis \_\_\_\_\_  Static  Progressive  Stable since \_\_\_\_\_ (date)

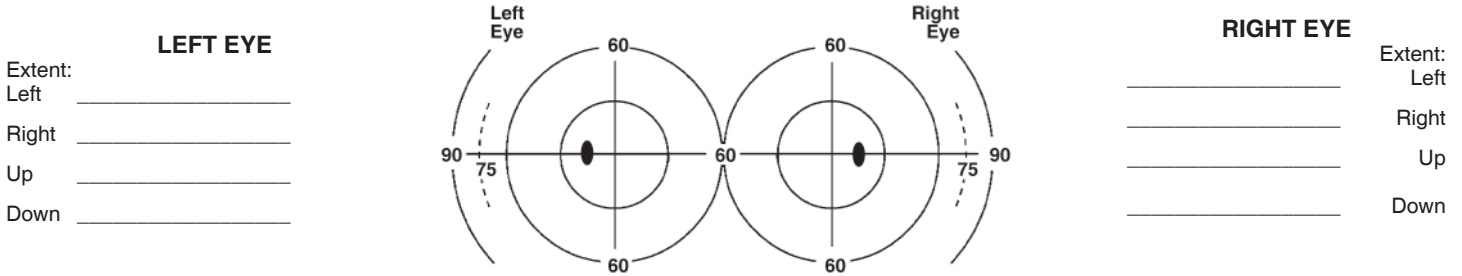
Diagnosis \_\_\_\_\_  Static  Progressive  Stable since \_\_\_\_\_ (date)

Diagnosis \_\_\_\_\_  Static  Progressive  Stable since \_\_\_\_\_ (date)

WHEN SHOULD DMV REQUIRE A NEW DMV VISION EXAMINATION REPORT FORM BE SUBMITTED?

Not applicable  1 year  2 years  5 years  Other \_\_\_\_\_

**5. VISUAL FIELDS** — If vision is not correctable to 20/40 in each eye, or there is possible visual field loss, a full visual field examination (confrontation is permissible) must be performed. Show the approximate peripheral extent and any **scotomas** in the diagram below.



**6. VISUAL ABNORMALITIES** — The following information will help our examiners evaluate your patient’s ability to safely operate a motor vehicle. Based upon your testing, clinical impression, or knowledge of the disorder, please indicate the severity of any of the following visual abnormalities which your patient may be experiencing. Indicate severity of condition by placing a 1 (mild), 2 (moderate), or 3 (severe) in the box(es) below.

Decreased Acuity	<input type="checkbox"/> <input type="checkbox"/>	Visual Field Loss	<input type="checkbox"/> <input type="checkbox"/>	Contrast Sensitivity Loss	<input type="checkbox"/> <input type="checkbox"/>	Problems With Glare	<input type="checkbox"/> <input type="checkbox"/>	Poor Night Vision	<input type="checkbox"/> <input type="checkbox"/>
Color Defect	<input type="checkbox"/>	Reduced Depth Perception	<input type="checkbox"/>	Abnormal Eye Movements	<input type="checkbox"/>				

**7. ADVICE** — Have you given your patient any advice about driving?  Yes  No If yes, please explain in #8 below.

**8. ADDITIONAL COMMENTS** — Report any additional information or comments you feel DMV should know concerning your patient’s visual and perceptual capabilities relating to driving performance. You may use an additional sheet of paper to provide this information as well as information about any existing conditions which contribute to poor night vision or poor depth perception, etc. Any recommendations about the patient’s general safety should also be made. **DMV will make the final licensing decision based on a combination of factors, including your professional expertise.**

**9. SIGNATURE** — This section must be completed to validate this report.

PRINTED NAME			M.D. OR O.D. LICENSE NUMBER
SIGNATURE			DATE OF EXAM (MUST BE WITHIN LAST 6 MONTHS)
ADDRESS	CITY	ZIP CODE	TELEPHONE NUMBER (      )