

REPORT OF VISION EXAMINATION

SECTION 1 — 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) §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.

final licensing deci						sion speciali	st.		
DRIVER LICENSE NUMBER					DATE OF BIRT	DATE OF BIRTH (MO., DAY, YR.)		HOME TELEPHONE NUMBER	
NAME (FIRST, MIDDLE, LAS	T)				1		·		
RESIDENCE ADDRESS				CITY			STATE	ZIP CODE	
information for its					le the Department ty to safely operate		hicle.	the following	
APPLICANT'S SIGNATURE							DATE		
			• 20/40 with bo	th eyes to	ested together, and		,		
DMV's Visual Acuity	Screening Stand	dard is	• 20/40 in one	eye, and					
			 20/70, at leas 						
SECTION 2 — OPI exam within last 6		ST OR OPTOME	TRIST COMPLE	TES THO	OSE SECTIONS THA	AT APPLY —	Information	must be from	
1. REFRACTION —	- Complete only	those sections	that apply.						
	HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED? DATE NEW LENSES WEF						NG RECOMMENDED?		
•					☐ Yes ☐ No				
By contact lenses					DID YOUR PATIENT RECEIV		RAINING?		
By refractive surgery					DID PATIENT RECEIVE BIOR		C THAT INCLUDED F	DDIVING2	
Is best corrected visua		e recommended for	driving? Yes	☐ No	Yes No I		3 THAT INCLUDED L	KIVING!	
Bioptic Telescope	Right eye 20/		Left eye 20/		SKILL IN USING BIOPTIC TI				
Bioptic Telescope suita	able for driving?	☐ Yes ☐ No			Satisfactory U	Jnsatisfactory			
2. VISUAL ACUITY				nses incl					
DMY	/ MEASUREMENT (F	OR DMV USE ONLY	Y) CLINICAL MEASUREMENT (WITHOUT BIO				IOPTIC TELESCOPE)		
	Both Eyes	Right Eye	Left Eye			Both Eyes	Right Eye	Left Eye	
With Current Lenges	20/	20/	20/	Without I		20/	20/	20/	
With Current Lenses	20/	20/	20/	With Len	rected Visual Acuity	20/	20/	20/	
3. DIAGNOSIS — F	Please indicate vis	sion condition by	checking the box		esenting affected eye		1	1	
write the diagnosi	is under "other dia	agnosis/comment	s" below.						
REFRACTIVE R L D		R L OPTICAL			TINAL/OPTIC NERVE R	. —	AL FIELDS	R L	
	mblyopia trabismus	Catarac Corneal	Opacity	□ Ma	betic Retinopathy Lcular Degeneration		eased Periphera mianopia		
	Congenital Nystagm		(uncorrectable)		aucoma	│	adrantanopia		
A	lbinism	∟∟ Keratoc Aphakia			tinal Detachment L tinitis Pigmentosa L	i 🧮 Decrea		n. Please identify the Section 5 (see reverse)	
		Pseudo _l	phakia	Re	tinal Damage		medica on the chartim	Jeetion J (Jee reverse)	
		Post. Ca	aps. Opac.		CRVO, PRP etc.)				
Other diagnosis/co	omments								
☐ Monocular Vision	(No Light Perception	on or Prosthesis)	If monocular, when	was the r	nonocular vision diagno	osed?			
If monocular, does	the patient have a	medical condition	that could affect the	e functiona	al eye in the future?	☐ Yes ☐ No			
Any eye surgery (inclu	ding refractive)?	☐ Yes ☐ No D	ate of most recent	surgery _	Тур	e of surgerv			

Name:			DL/ID/X #:	
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 EXAMIN		IITTED?		
 Not applicable □ 1 year □ 2 years □ VISUAL FIELDS — If vision is not corre 	<u> </u>	eve or there is nossible	a vieual field loss, a full vieual fie	ald examination (con
frontation is permissible) must be perfor	med. Show the approxi	mate peripheral extent	and any scotomas in the diagra	m below.
LEFT EYE	Left		Right RI	GHT EYE
Extent: Left	Eye 60	60	Eye	Extent Lef
Right	1, (\		Righ
Up		\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	1:1	U _F
Down	90 75	7 60 T	75 90	Dowr
	(, ()	$/\!\!\setminus\!$	/ · /	
- WOULD A DIVIDENT TO THE CHI	60	60	/	
 VISUAL ABNORMALITIES — The followhicle. Based upon your testing, clinical abnormalities which your patient may be box(es) below. 	al impression, or knowle	dge of the disorder, plea	ase indicate the severity of any o	of the following visua
R L Decreased Acuity	R L	R I	R L ☐ Problems With Glare ☐☐ Poor	R L
Color Defect Reduced Depth Po		ormal Eye Movements	Troblems with clare LL 1 ool	Trigitt vision ——
7. ADVICE — Have you given your patient	any advice about drivin	ıg? ☐ Yes ☐ No	If yes, please explain in #	#8 below.
8. ADDITIONAL COMMENTS — Report a and perceptual capabilities relating to di information about any existing condition the patient's general safety should also including your professional expertise	riving performance. You ns which contribute to p to be made. DMV will r	may use an additional oor night vision or poor	sheet of paper to provide this in depth perception, etc. Any reco	nformation as well as ommendations abou
9. SIGNATURE — This section must be	completed to validate	this report.		
PRINTED NAME			M.D. OR O.D. LICENSE NUM	MBER
SIGNATURE			DATE OF EXAM (MUST BE	WITHIN LAST 6 MONTHS)
X				
ADDRESS	CITY	CA	ZIP CODE TELEPHONE NUMBER	