EYE EXAMINATION AND PHYSICIAN OR OPTOMETRIST ASSESSMENT

Name (first, last, middle initial) _____

Visual Acuity: Right Eye ____ /____ Left Eye ____ /____ Both Eyes Together ____ /____

Used Corrective Lenses for exam? ☐ Yes ☐ No

Able to Drive Safely with current vision? ☐ Yes ☐ No

Special Driving Restrictions Recommended: ☐ Corrective Lenses ☐ Outside Mirrors ☐ Daylight Driving Only

Examiner's Name_____ Title_____

Signature of Examiner _____ Date of Exam: _____

Address: _____ Phone Number: _____

"Visual Acuity must be at least 20/40 using both eyes together, with or without corrective lenses to be qualified for a Driver License" Inability to see in either eye will require Outside Mirrors restriction