

**OFFICE OF MOTOR VEHICLES  
VISION EXAMINATION FORM  
P.O. BOX 64886 • BATON ROUGE, LA 70896-4886**

The bearer of this vision examination form is being required to undergo an examination by an optometrist or ophthalmologist. Authority for this requirement is based on laws of the State of Louisiana relating to the issuance of driver's licenses. The completed report of examination will be used by the Department of Public Safety and Corrections as a guide in making a final determination on the bearer's application which is now pending.

**NOTE TO APPLICANT:** This medical examination form must be completed by an optometrist or ophthalmologist and returned to this office within 30 days from the "DATE ISSUED" indicated below. Failure to comply will result in the suspension of your driving privileges.

**TO BE COMPLETED BY THE OFFICE OF MOTOR VEHICLES**

APPLICANT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_ R/S \_\_\_\_\_ D/L# \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
DATE ISSUED \_\_\_\_\_ MVCA'S INITIALS \_\_\_\_\_ BADGE # \_\_\_\_\_ OFFICE # \_\_\_\_\_

**OFFICE OF MOTOR VEHICLES RESULTS**

**WITHOUT CORRECTIVE LENSES:**

Right Eye 20 / \_\_\_\_\_  
Left Eye 20 / \_\_\_\_\_  
Both Eyes 20 / \_\_\_\_\_

**WITH CORRECTIVE LENSES:**

Right Eye 20 / \_\_\_\_\_  
Left Eye 20 / \_\_\_\_\_  
Both Eyes 20 / \_\_\_\_\_

TESTED ON WALL CHART:  YES  NO  
 APPLICANT FAILED TO COMPLY WITHIN 30 DAYS.

**TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST**

**NOTE TO PHYSICIAN:** In accordance with the provisions of R.S. 40:1356, a health care provider is exempt from any liability as a result of reporting to the Department of Public Safety and Corrections any visual ability, physical condition, impairment or disability which may impair a person's ability to exercise ordinary and reasonable control in the operation of a motor vehicle. This form must be completed in its entirety by an optometrist or ophthalmologist. Incomplete forms may be rejected and could result in the denial of this applicant's driving privileges.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**WITHOUT CORRECTIVE LENSES:**

Right Eye 20 / \_\_\_\_\_  
Left Eye 20 / \_\_\_\_\_  
Both Eyes 20 / \_\_\_\_\_

**WITH CORRECTIVE LENSES:**

Right Eye 20 / \_\_\_\_\_  
Left Eye 20 / \_\_\_\_\_  
Both Eyes 20 / \_\_\_\_\_

**WITH NEW Rx:**

Right Eye 20 / \_\_\_\_\_  
Left Eye 20 / \_\_\_\_\_  
Both Eyes 20 / \_\_\_\_\_

**PERIPHERAL VISION FIELDS:** Left \_\_\_\_\_

ANGLE OF VISION

Temporal

Nasal

Right \_\_\_\_\_

Temporal

Nasal

- 1 - Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors?  Yes  No
- 2 - In your opinion, should the patient wear corrective lenses to operate a motor vehicle?  Yes  No  
Does applicant use bioptic lens to drive?  Yes  No NOTE: Bioptic vision statement may be required.
- 3 - Is there evidence of eye disease or injury that would affect the driving ability? \_\_\_\_\_  
If so, describe \_\_\_\_\_
- 4 - In your opinion, should the patient be restricted to "Daylight Driving Only"? \_\_\_\_\_
- 5 - Do you recommend that an operator's license be denied on visual grounds? \_\_\_\_\_ If so, upon what grounds? \_\_\_\_\_
- 6 - In your opinion, from a visual standpoint, can this patient safely operate a motor vehicle? \_\_\_\_\_
- 7 - Should the patient have vision checked more frequently than every four years for driving purposes? \_\_\_\_\_  
If yes, list medical reasons \_\_\_\_\_ How often? \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Physician's Printed Name \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_  
Physician's Address \_\_\_\_\_

**TO BE COMPLETED BY APPLICANT**

I hereby authorize the examining physician whose signature appears above to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

Date \_\_\_\_\_ Signature of Patient \_\_\_\_\_