

Visual Examination Report

Mail or fax completed report to:
Restricted Licensing
Department of Licensing
PO Box 9030
Olympia, WA 98507
 Fax: **(360) 570-7893**
 Email: **MedicalCerts@dol.wa.gov**

Failure to return this completed form by _____ to Department of Licensing (DOL) may result in the suspension of the driver's driving privilege.

| Driver/Patient information | | |
|--|--------------------------------------|-------------------------------------|
| Name (Last, First, Middle) | | |
| Date of birth | (Area code) Daytime telephone number | Driver license number |
| Consent to release information <i>I authorize the ophthalmologist/optometrist below to provide clarification or information regarding my visual condition based on an examination conducted within the past year. I understand the Department of Licensing will use this information to arrive at a decision regarding my ability to safely operate a motor vehicle.</i> | | |
| X | | X |
| Driver signature | Date | Signature of parent (if minor) Date |

| Ophthalmologist/Optometrist | | | | | | |
|---|--------------------|-------------|-----------------|--------------|-------------|-------------|
| DOL has reason to believe the driver named above may have a condition that could affect the safe operation of a motor vehicle. | | | | | | |
| Your knowledge of this person's condition is of great value in assisting us determine a proper licensing decision. DOL has sole responsibility for any decision regarding driving qualifications and licensure. Answer ALL questions and return to DOL. | | | | | | |
| Date of examination (within past year) | Without correction | | With correction | | | |
| | Right 20/ | Left 20/ | Both 20/ | Right 20/ | Left 20/ | Both 20/ |
| Answer the following | | | | | | |
| 1. This individual's best attainable visual acuity is | | | | | | |
| Vision that is not at least 20/70 Snellen range with correction, is deemed unqualified to drive at night. | | | | | | |
| 2. Was testing done with a visual acuity correction device: bioptic/telescopic lens? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 3. Field of vision: Is this individual's total visual field less than 110 degrees in horizontal meridian with a test object? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| If "Yes", visual field is: Left temporal _____ degrees Right temporal _____ degrees | | | | | | |
| If "Yes", have you noticed a decline in the field of vision in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| 4. Does this individual have subjective diplopia and was tested for it? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| If "Yes", how is the compensation achieved? _____ | | | | | | |
| 5. Should DOL monitor this driver's condition with periodic Visual Examination Reports? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| If "Yes", how often? <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years | | | | | | |
| Comments/Other conditions that may affect this person's driving | | | | | | |

| | | |
|--|-------------------------------|---|
| Ophthalmologist/Optometrist name | | Professional license number |
| Address (Street address, City, State, ZIP code) | | |
| (Area code) Telephone number | (Area code) Fax number | Email |
| I certify under penalty of perjury under the laws of the state of Washington that the information I have provided is true and correct. | | |
| Date | Place (city or county) signed | X Ophthalmologist/Optometrist signature |