

REPORT OF EYE EXAMINATION

To be completed by an optometrist, ophthalmologist, physician assistant, certified registered nurse practitioner, or licensed physician with equipment to properly evaluate vision



Bureau of Driver Licensing
P.O. Box 68682
Harrisburg, PA 17106-8682
(717) 787-9662

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK ALL INFORMATION

PATIENT INFORMATION Are you a CDL driver? YES NO

DRIVER'S LICENSE NO.		LAST NAME(S)			JR. ETC	FIRST NAME	
HEIGHT		SEX	EYE COLOR		DATE OF BIRTH		TELEPHONE NUMBER
FEET	INCHES		MONTH	DAY	YEAR	E-MAIL ADDRESS: (if applicable)	
STREET ADDRESS: <i>P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.</i>					CITY	STATE	ZIP CODE

REGULAR DRIVER (CLASS A, B, C & M)

- Please indicate individual's visual acuity by marking the appropriate box:
 A. Combined vision is 20/40 or better. . . .With Correction W/O Correction
 B. Combined vision is poorer than 20/40 but has been corrected to 20/60 or better.
 C. Combined vision is poorer than 20/60 but has been corrected to at least 20/70.
 a) Do you consider this person visually capable to drive? Yes No
 D. Combined vision is poorer than 20/70 and not correctable to 20/70.

UNCORRECTED	
R	20/
L	20/
B	20/

CORRECTED	
R	20/
L	20/
B	20/

- Is individual's combined field of vision at least 120° in the horizontal meridian, excepting the normal blind spots?
- Does individual have better than 20/100 vision in each eye with correction?
- Must individual wear corrective lenses?
- Does this individual no longer require corrective lenses as a result of corrective surgery?
- Is correction obtained through telescopic lenses?
- Does this individual's condition warrant monitoring by the Department?
If so, how often? _____
- Are there any other conditions or diseases present that may make this individual an unsafe driver?
If so, please explain: _____

CHECK ONE: YES NO

SCHOOL BUS DRIVERS (S ENDORSEMENT):

- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 1. Individual has distant visual acuity of at least 20/40 in the BETTER eye without corrective lenses or visual acuity corrected to 20/40 or better? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Individual has at least 20/50 in the POORER eye without corrective lenses or visual acuity corrected to 20/50 or better? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Individual has distant binocular acuity of at least 20/40 in both eyes with or without corrective lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is individual's combined field of vision at least 160° in the horizontal meridian, excepting the normal blind spots? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Individual has the ability to determine colors used in traffic signals and devices showing standard red, green or amber. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Individual must wear corrective lenses | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the patient had an annual dilated eye exam? If yes, date of last exam: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does this individual's condition warrant monitoring by the Department? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, how often? _____ | | |
| 9. Are there any other conditions or diseases present that may make this individual an unsafe driver? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please explain: _____ | | |

HEALTH CARE PROVIDER'S INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME		SPECIALTY		STATE MEDICAL LICENSE #	
STREET ADDRESS		CITY		STATE	ZIP CODE
TELEPHONE #			FAX #		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to \$2,500 and/or imprisonment up to 1 year.

Health Care Provider's Signature _____

Date _____