



Georgia Department of Driver Services

Vision Form- Online Renewal Only **(64 years and older)**

Instructions: Complete the "Driver/Patient Section" below. After completing the "Driver/Patient Section," have your optometrist/ ophthalmologist complete and sign the "Optometrist/Ophthalmologist Section." Once the form is complete, log into your online account and upload the document. (**Do not use this form for CDL drivers**)

Driver/Patient Section		
Last Name:	First Name:	Middle Initial
Mailing Address:	City/ State:	ZIP Code:
Customer's Driver License Number (DL#):	Date of Birth:	
I hereby authorize my Optometrist/Ophthalmologist to complete and sign this form to provide information about my visual acuity to the Georgia Department of Driver Services (DDS). relating to the date and result of an eye examination, for the purpose of renewing or obtaining my Georgia Driver's license.		
Signature of Driver/ Patient		Date:
Optometrist/Ophthalmologist Section		
Full Name (Please Print)	Medical License Number and State	
Mailing Address:	City/State/Zip Code:	Phone Number:
Pursuant to Georgia Law (O.C.G.A. § 40-5-27). A driver must meet the following vision requirements to be issued a license: <ul style="list-style-type: none">• Acuity of 20/60 or better, corrected, or uncorrected in at least one eye• Visual Horizontal field of vision with both eyes open of at least 140 degrees• If only one eye has usable vision, the horizontal field of vision must be at least 70 degrees temporally and 50 degrees nasally.		
Please make selection below based on your examination and DDS requirements: <p>Patient meets vision requirements to safely operate a motor vehicle.</p> <p>Patient meets vision requirements, but the following restrictions should be imposed for safety:</p> <ul style="list-style-type: none">B- Corrective lenses are required for driving.R- No ExpresswaysG- Daylight Hours only (If difficulty seeing in dim light or at night)1- Bioptic lenses <p>Patient does not have sufficient vision to safely operate a motor vehicle.</p> <p>Please provide reason(s):</p>		
Signature of Optometrist/Ophthalmologist:		Date of Examine: