CDL Vision Exemption Form

TO APPLICANT:

Please complete pages 1 and 2 of this CDL Vision Exemption Form. Have your optometrist or ophthalmologist complete the CDL Vision Report (pages 3 and 4 of this form). The form must be mailed to the address listed at the bottom of page 4. Please review the form prior to having it mailed. **Incomplete applications cannot be processed**.

Select one of the following options:

☐ **Initial Request for Exemption** ☐ **Renewal Exemption Application**

Part 1: Vital Statistics (Required information)

Full Name (Last, First, Middle)				
Mailing Address				
City		State	Zip Code	Telephone Number
Georgia Driver's License Number	Issue Date	Expiration Date	Current License Class:	

Part 2: Experience (Please provide a response to those that apply):

- Number of years driving straight trucks: _____
- Approximate number of miles per year driving straight trucks: _____
- Number of years driving combination vehicles: _____
- Approximate number of miles per year driving combination vehicles: _____
- Number of years driving buses: _____
- Approximate number of miles per year driving buses: _____

Part 3: Present Employment (Required information)

Employer's Name			
Employers Address	City	State	Zip Code
Employer's Telephone Number	Type of Vehicle Operated		GVWR

Estimated Number of Miles Driven Per Week:	Estimated Number of Daylight Driving Hours Per Week:	Estimated Number of Nighttime Driving Hours Per Week:

Part 4: Supporting Documentation

Your application **must** include supporting documents for each area listed below:

- A photo copy of both sides of your current driver's license (CDL or non-CDL)
- If address on application is different than the address on your driver's license you must indicate on the bottom of page 2 why the address on the license is different than the address on the application
- Provide documentation that you have been examined by an ophthalmologist or an optometrist in the last 3 months. A CDL Vision Report is included as part of this packet for your convenience.
- DDS will obtain and review your MVR (driving record) for three years. You must have a Georgia license to apply for the CDL Vision Exemption. **Your application will only be considered if the driving record:**
    - Contains no suspensions, withdrawals, or revocations of your driver's license for the operation of **any** motor vehicle (including your personal vehicle);
    - Contains no involvement in an accident for which you contributed or received a citation for a moving traffic violation;
    - Contains no convictions for a disqualifying offense, as defined in 49CFR383.51(b)(2), or more than one serious traffic violation, as defined in 49 CFR 383.5, while driving a CMV during the 3 year period, which disqualified or should have disqualified you in accordance with the driver qualification provisions of 49 CFR 383.51;
    - Contains no more than two convictions for any other moving traffic violations
- Upon receipt of current and complete information, an individual evaluation for an exemption from the Federal vision standard will be conducted, and you will be notified of the results. If you do not provide this information, your application will be rejected**. An exemption may be issued for a maximum of two (2) years, but may be renewed at the discretion of the State (Department of Driver Services)**. Any exemption issued in response to your application is valid for operations only within the State of Georgia. It does not exempt you from having to meet all other physical qualifications, nor does it exempt you from the physical qualifications from any bordering jurisdiction(s).

Part 5: Self Certification

"I acknowledge that I must be otherwise qualified under 49 CFR 391.41(b)(1-13) or hold another valid medical exemption before I can legally operate a commercial motor vehicle."

_____ _____

Signature of Applicant **Date**

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GEORGIA DEPARTMENT OF DRIVER SERVICES
CDL VISION REPORT
(Must be completed by Optometrist or Ophthalmologist)

APPLICANT DRIVERS LICENSE NO. _____ EXAMINATION DATE: _____

APPLICANT'S FULL NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ DOB: _____

TO EXAMINING DOCTOR:

Please complete this CDL Vision Report in its entirety. Please leave blank any spaces for tests on which you have made no examination. If the case is peculiar, additional comments on a separate sheet would be appreciated.

This section must be completed.

REPORT ON VISUAL ACUITY EXAMINATION

DISTANT VISION ONLY	RIGHT EYE	LEFT EYE	BOTH EYES
WITHOUT GLASSES	20/_____	20/_____	20/_____
WITH PRESENT GLASSES	20/_____	20/_____	20/_____
WITH NEW PRESCRIPTION	20/_____	20/_____	20/_____
WITH BIOPTIC PRESCRIPTION	20/_____	20/_____	20/_____

IF POSSIBLE MEASURE ABOVE AT 20 FEET, IF NOT STATE DISTANCE USED: _____

☐ Check here if correction is achieved with other than conventional lenses (bioptics). If box is checked a detailed report must be attached.

This section must be completed. Cannot contain words such as 'full' or 'normal'

FIELDS-HORIZONTAL MERIDIAN: MUST BE MEASURED IN DEGREES

RIGHT: _____DEGREES LEFT:_____DEGREES TOTAL: _____DEGREES

EVIDENCE OF SUPPRESSION: _____

COORDINATION AT 20 FEET EXO_____ ESO_____ RT.H_____ LF.H_____

FUSION-DISTANCE: EXCELLENT GOOD POOR NONE TEST USED:_____

FUSION-NEAR: EXCELLENT GOOD POOR NONE TEST USED: _____

DEPTH PERCEPTION: EXCELLENT GOOD POOR NONE TEST USED: _____

This section must be completed.

COLOR VISION (ability to distinguish red/green/amber): NORMAL DEFICIENT FAILED TEST USED: _____

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Please identify and define the nature of the vision deficiency, including how long the patient has had the vision deficiency: _____

_____

_____

Has the vision deficiency remained stable for the previous five years: ☐ Yes ☐ No

Are corrective lenses needed for distant vision? _____ For near vision? _____ Is there any double vision: _____ If so, is it corrected with glasses or other treatment? _____

Any evidence of eye disease or injury? _____ If so, describe: _____

_____

_____

Can this be corrected or compensated for? _____

Any difficulty in seeing in dim light or at night? _____

Examining professional MUST answer this question:

In your opinion, does this person have sufficient vision to operate a **commercial motor vehicle safely**? _____ If, yes should there be any restrictions imposed? _____ If so what restrictions?

_____

COMMENTS: _____

CERTIFICATION OF VISION SPECIALIST

I, _____ being licensed to practice in Georgia, certify that I have personally examined the vision of the above named person, that a true record of this examination appears on this report and that he or she signed this form in my presence.

Signature of examining doctor	State license #	Date

Printed name of examining doctor	Office telephone number (include area code)

Business Street Address	City	State	Zip Code

IMPORTANT: For proper identification, please ensure that you have obtained picture identification of the person being examined and that that is the person identified on this vision report. Have the person whom you have examined sign the report in your presence.

Signature of applicant (person having eye exam)	Date

PHYSICIAN MUST MAIL ORIGINAL COMPLETED FORM (ALL 4 PAGES) TO:

DEPARTMENT OF DRIVER SERVICES
ATTN: CDL Unit
P.O. Box 80447
Conyers, GA 30013