



## GEORGIA DEPARTMENT OF DRIVER SERVICES VISION REPORT

### INSTRUCTIONS

#### **IMPORTANT:**

1. This report **MUST** be completed by a licensed optometrist or ophthalmologist. (**This report should not be completed for Commercial Motor Vehicle Drivers.**)
2. If cleared to drive without the addition and/or removal of license restriction(s), a **Non-Biopic** customer may return this form to any Department of Driver Services Customer Service Center.
3. If you do not meet the requirements outlined in #2 (above), all pages of this report should be mailed or faxed (with coversheet) by a licensed optometrist or ophthalmologist directly to:

Department of Driver Services  
Medical Review Unit  
P. O. Box 80447  
Conyers, Georgia 30013 or  
Fax to (770) 344-3629

### PATIENT INFORMATION

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_  
Physical Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Phone Number \_\_\_\_\_ Email \_\_\_\_\_

### PATIENT ATTESTATION

I authorize \_\_\_\_\_, a licensed optometrist or ophthalmologist, to complete this examination and to provide further clarification or information about my visual acuity to the Georgia Department of Driver Services (DDS). I agree that this Vision Report may be submitted to the DDS Driver's License Advisory Board, which consists of doctors licensed to practice throughout the State of Georgia, and that it may also be used for the guidance of the courts when necessary.

\_\_\_\_\_  
**Driver/Licensee Signature**

\_\_\_\_\_  
**Date**

### REPORT ON VISUAL EXAMINATION

**Pursuant to Georgia Law (O.C.G.A. §40-5-27) a driver must meet the following vision requirements to be issued a license:**

- Visual acuity of 20/60 or better, corrected, or uncorrected in at least one eye
- 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.

If possible, measure the below at 20 feet. If not, state the distance used: \_\_\_\_\_

#### **BEST CORRECTED VISUAL ACUITY (BCVA)**

Please state the visual acuity in degrees.

	<u><b>RIGHT EYE</b></u>	<u><b>LEFT EYE</b></u>	<u><b>BOTH EYES</b></u>
<b>Without corrective lenses</b>	20/ _____	20/ _____	20/ _____
<b>With corrective lenses</b>	20/ _____	20/ _____	20/ _____
<b>With biopic telescope</b>	20/ _____	20/ _____	20/ _____

**HORIZONTAL PERCEPTION (Must be tested)**

Please state the horizontal field of vision in degrees.

**Right:** \_\_\_\_\_ degrees **Left:** \_\_\_\_\_ degrees **Total:** \_\_\_\_\_ degrees

**MONOCULAR VISION**

Does this person have monocular vision? ☐ Yes ☐ No If yes, please state the nasal and temporal fields in degrees.

**NASAL FIELD** \_\_\_\_\_ degrees **TEMPORAL FIELD** \_\_\_\_\_ degrees

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

**VISION REPORT PHYSICIAN'S STATEMENT**

**Date of Examination (mm/dd/yyyy):** \_\_\_\_\_

1. Is there double-vision? ☐ Yes ☐ No If 'Yes', is it corrected with glasses or other treatment? ☐ Yes ☐ No

2. Is there any evidence of eye disease, condition, or injury? ☐ Yes ☐ No If 'Yes', please describe:

\_\_\_\_\_

\_\_\_\_\_

a. Can this be corrected or compensated for? ☐ Yes ☐ No ☐ NA

3. In your opinion, does this person have sufficient vision to safely operate a motor vehicle? ☐ Yes ☐ No

a. If yes, should any restrictions be imposed? ☐ Yes ☐ No If 'Yes', please check the applicable restriction(s) below:

**Restriction Code/Description**

- |                          |       |   |   |
|--------------------------|-------|---|---|
| <input type="checkbox"/> | 1     | - | Bioptic lenses required   |
| <input type="checkbox"/> | B     | - | Corrective lenses required  |
| <input type="checkbox"/> | G     | - | Daylight hours only (if difficulty seeing in dim light or at night) |
| <input type="checkbox"/> | F     | - | Right exterior mirror required                                      |
| <input type="checkbox"/> | I     | - | Left exterior mirror required                                       |
| <input type="checkbox"/> | R     | - | No Highway/Interstate   |
| <input type="checkbox"/> | Other | - | Please explain  |

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN ACKNOWLEDGEMENT**

I, \_\_\_\_\_, being licensed to practice optometry/ophthalmology, certify that I have personally examined the vision of the above-named individual, that a true record of this examination appears on this report and that he or she signed this form in my presence.

Name of Practice \_\_\_\_\_

Physician Full Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_

Specialty: \_\_\_\_\_

License Number/State \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**