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 Drivers. Commercial Drivers must have the CDL Vision Exemption Form (DDS-VE1) submitted by their licensed optometrist or ophthalmologist.)**
2. If cleared to drive, a **Non-Bioptic** customer may return this form to any Department of Driver Services Customer Service Center.
3. If NOT cleared to drive OR you are a **Bioptic** driver, all pages of this report MUST 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 # ______________________

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
- In the event that 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: ________________________________

BINOCULAR VISION (BCVA)

Please state the Binocular total horizontal visual field in degrees.

	RIGHT EYE	LEFT EYE	BOTH EYES
Without glasses	20/ ______	20/ ______	20/ ______
With existing prescription	20/ ______	20/ ______	20/ ______
With new prescription	20/ ______	20/ ______	20/ ______
With bioptic prescription	20/ ______	20/ ______	20/ ______

Patient Name: Last: ______________ First: ______________ M.I.: ______

HORIZONTAL PERCEPTION (Must be completed)

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 (bioptics). If box is checked, a detailed report must be attached.

VISION REPORT PHYSICIAN'S STATEMENT

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 injury? ☐ Yes ☐ No If 'Yes', please describe:

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a. Can this eye injury 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

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

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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**