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-Bioptic** 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 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: _____

BEST CORRECTED VISUAL ACUITY (BCVA)

Please state the visual acuity in degrees.

	RIGHT EYE	LEFT EYE	BOTH EYES
Without corrective lenses	20/ _____	20/ _____	20/ _____
With corrective lenses	20/ _____	20/ _____	20/ _____
With bioptic telescope	20/ _____	20/ _____	20/ _____

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

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

☐	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

_____

_____

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**