

PLEASE RETURN COMPLETED STATE OF KANSAS DIRECTOR OF VEHICLES
VISION FORM TO:

MEDICAL/VISION UNIT
915 HARRISON STREET
PO BOX 2188
TOPEKA KS 66601-2188

PH: Telephone: (785) 368-8971
FAX: FAX: (785) 296-5857

KANSAS DIVISION OF VEHICLES VISION FORM

GENERAL INFORMATION & HISTORY – TO BE FILLED OUT BY THE PATIENT

NAME: _____ DRIVER LICENSE #: _____ DOB: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE #: _____

Currently enrolled in Driver’s Education? YES / NO If yes, instructor name & phone number: _____

RELEASE OF INFORMATION

Permission is granted for release of all vision information concerning me to the Kansas Division of Vehicles by all medical professionals filling out this form.

SIGNATURE OF PATIENT

DATE

To the Vision Professionals: You assume no responsibility in making this report other than that of truthfully representing the facts as they appear in your professional judgment. The information on this form must be from an examination within the last 90 days.

Instructions:

- 1. Please answer each question and fill out the entire form carefully and legibly.
- 2. Indicate yes or no whether from a visual standpoint only, this patient is capable of safely operating a motor vehicle.
- 3. Specify any driving restrictions that are appropriate based on the patient’s vision condition.

If you have any questions please call (785)368-8971.

SECTION I: VISION REPORT

	<u>Acuity Right Eye</u>	<u>Acuity Left Eye</u>	<u>Both Eyes</u>	<u>Horizontal Field of Vision</u>
Visual Acuity without Glasses	20/_____	20/_____	20/_____	Equal to or greater than 20°? <input type="checkbox"/> Yes <input type="checkbox"/> No
Visual Acuity with Glasses	20/_____	20/_____	20/_____	
Best Correction	20/_____	20/_____	20/_____	
Bioptic/Telescopic (if prescribed for driving)	20/_____	20/_____	20/_____	

- Does this patient require a drive test? Yes No
- This patient is capable of safely operating a motor vehicle.** Yes No
- (Driver must be considered a safe candidate in order to request a drive test.)**
- An annual vision report should be required. Yes No
- Does this patient require a medical exam? Yes No

Indicate below which restrictions may apply to the patient’s license if issued or continued: Maximum 6 restrictions.

- Corrective Lenses
- Daylight Hours Only
- No Interstate Driving
- Outside Business Area
- Within City Limits
- Licensed Driver in Front Seat
- Automatic Transmission
- Outside Mirror
- Mechanical Aid
- Prosthetic Aid
- _____ Miles From Home (5-30 in 5 mile increments)

Name of Optometrist/Ophthalmologist (Please print)

Date of Examination

Address

Signature of Optometrist/Ophthalmologist

Phone

Date Signed