OFFICE OF MOTOR VEHICLES
VISION EXAMINATION FORM
P.O. BOX 64886 • BATON ROUGE, LA 70896-4886

The bearer of the vision examination form is required to undergo an examination by an optometrist or ophthalmologist. Authority for this requirement is based on laws of the State of Louisiana relative to the issuance of driver's licenses. The completed report will be used by the Department of Public Safety and Corrections as a guide in making a final determination on the bearer's application which is now pending.

NOTE TO APPLICANT: This medical examination form must be completed by an optometrist or ophthalmologist and returned to this office within 30 days from the "DATE ISSUED" indicated below. Failure to comply will result in the suspension of your driving privileges.

TO BE COMPLETED BY THE OFFICE OF MOTOR VEHICLES

APPLICANT'S NAME _____ DOB _____ R/S _____ D/L# _____

ADDRESS _____ CITY _____

DATE ISSUED _____ MVCA'S INITIALS _____ BADGE # _____ OFFICE # _____

OFFICE OF MOTOR VEHICLES RESULTS

WITHOUT CORRECTIVE LENSES:		WITH CORRECTIVE LENSES:	
Right Eye	20 / _____	Right Eye	20 / _____
Left Eye	20 / _____	Left Eye	20 / _____
Both Eyes	20 / _____	Both Eyes	20 / _____

TESTED ON WALL CHART: ☐ YES ☐ NO

☐ **APPLICANT FAILED TO COMPLY WITHIN 30 DAYS.**

TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST

NOTE TO PHYSICIAN: In accordance with the provisions of R.S. 40:1356, a health care provider is exempt from any liability as a result of reporting to the Department of Public Safety and Corrections any visual ability, physical condition, impairment or disability which may impair a person's ability to exercise ordinary and reasonable control in the operation of a motor vehicle. This form must be completed in its entirety by an optometrist or ophthalmologist. Incomplete forms may be rejected and could result in the denial of this applicant's driving privileges.

Patient's Name: _____ Date of Birth: _____/_____/_____

WITHOUT CORRECTIVE LENSES:		WITH CORRECTIVE LENSES:		WITH NEW Rx:	
Right Eye	20 / _____	Right Eye	20 / _____	Right Eye	20 / _____
Left Eye	20 / _____	Left Eye	20 / _____	Left Eye	20 / _____
Both Eyes	20 / _____	Both Eyes	20 / _____	Both Eyes	20 / _____

PERIPHERAL VISION FIELDS: ANGLE OF VISION — Left _____ (Temporal / Nasal) Right _____ (Temporal / Nasal)

1 - Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors? ☐ Yes ☐ No

2 - In your opinion, should the patient wear corrective lenses to operate a motor vehicle? ☐ Yes ☐ No

Does applicant use bioptic lens to drive? ☐ Yes ☐ No NOTE: Bioptic vision statement may be required.

3 - Is there evidence of eye disease or injury that would affect the driving ability? _____

If so, describe _____

4 - In your opinion, should the patient be restricted to "Daylight Driving Only"? _____

5 - Do you recommend that an operator's license be denied on visual grounds? _____ If so, upon what grounds? _____

_____

6 - In your opinion, from a visual standpoint, can this patient safely operate a motor vehicle? _____

7 - Should the patient have vision checked more frequently than every four years for driving purposes? _____

If yes, list medical reasons _____ How often? _____

Physician's Signature _____ Date _____

Physician's Printed Name _____ Telephone # (_____)_____

Physician's Address _____

TO BE COMPLETED BY APPLICANT

I hereby authorize the examining physician whose signature appears above to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

Date _____ Signature of Patient _____