



Instructions: Print clearly and legibly. If any section of this form is incomplete, it may have to be returned to the vision specialist for completion.

APPLICANT INFORMATION

FULL NAME (Printed)	DRIVER LICENSE NUMBER
MAILING ADDRESS (including city, state, zip)	DATE OF BIRTH

THIS FORM MAY ONLY BE COMPLETED & SIGNED BY A QUALIFIED VISION SPECIALIST — If needed to meet annual requirement, must be from exam within last 3 months.

HOW LONG HAS THE ABOVE APPLICANT BEEN YOUR PATIENT?

REQUIRED: VISUAL ACUITY (Lenses include contact lenses or glasses)

	Right Eye	Left Eye	Both Eyes
Without Lenses	20/	20/	20/
With Lenses	20/	20/	20/
With Bioptic Telescope <input type="checkbox"/> N/A	20/	20/	20/

WYOMING VISION STANDARDS

DRIVER'S LICENSE:

- 20/40 or better with both eyes with or w/o corrective lenses, and
- total combined horizontal field of vision, with both eyes, of at least 120 degrees, or if blind in one eye, at least 60 degrees in the other eye.
- If best visual acuity with or w/o corrective lenses is worse than 20/100 in the carrier lenses, the bioptic telescope must correct the visual acuity to at least 20/40.

NOTE: A 20/50 - 20/100 combined visual acuity may require a re-exam.

COMMERCIAL DRIVER'S LICENSE:

- 20/40 or better in each eye with or w/o corrective lenses, and
- horizontal field of vision is at least 70 degrees in each eye; for at least a combined total field of 140 degrees with both eyes.

Standards listed in their entirety are available at www.dot.state.wy.us.

YES NO Does the patient's horizontal visual field meet Wyoming Vision Standards?

EXAMINATION INFORMATION

(check all that apply and please do not abbreviate)

Applicant is currently being treated for one or more of the following progressive ocular condition(s):

- MACULAR DEGENERATION CATARACTS GLAUCOMA
 OTHER _____ N/A

YES NO This patient should be required to submit a "Driver Vision Evaluation" annually to the Department to determine if patient meets licensing standards. (If NO, please explain below under "Additional Information")

IN MY PROFESSIONAL OPINION

(check all that apply and please do not abbreviate)

- this patient's condition renders him/her incapable of safely operating any type of motor vehicle.
 this patient's condition does not affect his/her ability to safely operate any type of motor vehicle.
 this patient's condition does not affect his/her ability to safely operate a private motor vehicle; however, he/she should not operate a heavy vehicle (Class A or B type vehicle).
 this patient should be required to wear a bioptic lens while driving *and* this patient's skill in using a bioptic lens is
 Satisfactory Unsatisfactory Not Known (please complete Visual Acuity with Bioptic Telescope above)
 the following restrictions should be placed on the applicant's driver license:
 NONE DAYLIGHT DRIVING ONLY
 NO INTERSTATE DRIVING POSTED SPEED NOT TO EXCEED _____ MPH
 SPECIFIC LIMITS OF TIME/DISTANCE/LOCATION: _____
 OTHER RESTRICTIONS: _____
 this patient should be required to complete a driving road test to determine if patient meets licensing standards.

ADDITIONAL INFORMATION

PRINT NAME OF QUALIFIED VISION SPECIALIST	CLASSIFICATION/SPECIALTY	MEDICAL/OPTOMETRY LICENSE NUMBER
MAILING ADDRESS (including city, state, zip)	CONTACT PHONE NUMBER	
AUTHORIZED SIGNATURE	DATE	

Should you have any questions regarding this form, please contact the Customer Service Desk at 307-777-4810.

Mail to: Wyoming Department of Transportation (WYDOT) **OR Fax to: 307-777-4922**
Driver Services - Driver Review Section
5300 Bishop Boulevard, Cheyenne, WY 82009-3340 **http://www.dot.state.wy.us/home/driver_license_records.html**