



**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-Biopic** customer may return this form to any Department of Driver Services Customer Service Center.
3. If **NOT** cleared to drive **OR** you are a **Biopic** 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.

	<u>RIGHT EYE</u>		<u>LEFT EYE</u>		<u>BOTH EYES</u>
Without glasses	20/ _____		20/ _____		20/ _____
With existing prescription	20/ _____		20/ _____		20/ _____
With new prescription	20/ _____		20/ _____		20/ _____
With biopic prescription	20/ _____		20/ _____		20/ _____

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:

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

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