Central Services and Records Division
Reno/Sparks/Carson City (775) 684-4DMV (4368)
Las Vegas Area (702) 486-4DMV (4368)
Rural Nevada (877) 368-7828
Website: www.dmvnv.com

Physical Evaluation Form

Driver's License Renewal by Mail

NRS 483.383-483.384, NAC 483.420-483.455

Sections 1 and 2 must be signed and dated not more than 90 days before the date this form is submitted to the Nevada DMV. Section 1, the Vision report, must be completed, signed, and dated by a licensed ophthalmologist, optometrist, or physician. Section 2, the Medical report, must be completed, signed, and dated by a licensed physician. Please return this Physical Evaluation Form with your application and fees payment to renew your driver's license by mail. Unless otherwise instructed, all parts of this form must be completed in full to avoid any delays of your renewal.

Please clearly* PRINT *the following information:

Driver's Name _____

Address _____

Driver's License Number _____ Date of Birth _____ Age _____

Section 1 – Vision *(must be completed by licensed ophthalmologist, optometrist or physician)*

	Without Corrective Lenses	With Corrective Lenses
Right Eye	20/	20/
Left Eye	20/	20/
Both Eyes	20/	20/

Does this person have a progressive disease or condition of the eye? ..... ☐ Yes ☐ No

_____ _____

Signature of Licensed Ophthalmologist, Optometrist, or Physician

Date of Vision Examination
(Must be within the last **90** days)

_____ (_____) _____

PRINTED Name of Ophthalmologist, Optometrist, or Physician License Number Area Code and Phone Number

_____

Office Address of Ophthalmologist, Optometrist, or Physician

Section 2 - Medical *(must be completed by a licensed physician)*

Does a medical condition exist that would prevent this patient from operating a motor vehicle safely? ..... ☐ Yes ☐ No

If "Yes," please explain: _____

Is this patient taking any medication that would affect his/her ability to drive safely? ..... ☐ Yes ☐ No

If "Yes," please explain: _____

_____ _____

Signature of Licensed Physician

Date of Medical Evaluation
(Must be within the last **90** days)

_____ (_____) _____

PRINTED Name of Physician Physician's License Number Physician's Area Code & Phone No.

_____

Office Address of Physician