STATE OF CALIFORNIA
DMV
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

REPORT OF VISION EXAMINATION

962

SECTION 1 — APPLICANT COMPLETES THIS SECTION

INSTRUCTIONS: Please complete the driver license number, date of birth, telephone number, name, and address areas of this form. **You must sign and date the authorization line.** All medical information received by the Department of Motor Vehicles (DMV) is confidential under *California Vehicle Code* (CVC) §1808.5. Please bring this completed form and any new corrective lenses with you when you return to DMV for further testing. If any section of this form is incomplete, it may have to be returned to the vision specialist for completion. **DO NOT MAIL THIS FORM BACK TO DMV** unless asked to do so by a DMV employee. **Alterations or erased information may void this form.**

Your vision specialist should conduct a new vision examination unless one has been conducted within the last six months. **DMV will make the final licensing decision based on a combination of factors, including information from your vision specialist.**

DRIVER LICENSE NUMBER	DATE OF BIRTH (MO., DAY, YR.)	HOME TELEPHONE NUMBER
		( )

NAME (FIRST, MIDDLE, LAST)

RESIDENCE ADDRESS | CITY | STATE | ZIP CODE

I authorize the vision specialist conducting this examination to provide the Department of Motor Vehicles with the following information for its confidential use (CVC §1808.5) in evaluating my ability to safely operate a motor vehicle.

APPLICANT'S SIGNATURE | DATE

DMV's Visual Acuity Screening Standard is
- 20/40 with both eyes tested together, **and**
- 20/40 in one eye, **and**
- 20/70, at least, in the other eye.

SECTION 2 — OPHTHALMOLOGIST OR OPTOMETRIST COMPLETES THOSE SECTIONS THAT APPLY — Information must be from exam within last 6 months.

1. REFRACTION — Complete only those sections that apply.

HAVE NEW DISTANCE LENSES BEEN PRESCRIBED AND FITTED?
☐ Yes ☐ No If yes: ☐ Glasses ☐ Contact Lenses

DATE NEW LENSES WERE PRESCRIBED

IS NIGHT DRIVING RECOMMENDED?
☐ Yes ☐ No

IS MONOVISION EMPLOYED?
By contact lenses ☐ Yes ☐ No
By refractive surgery ☐ Yes ☐ No
Is best corrected visual acuity in each eye recommended for driving? ☐ Yes ☐ No

DID YOUR PATIENT RECEIVE BIOPTIC LENS TRAINING?
☐ Yes ☐ No ☐ Not Known

DID PATIENT RECEIVE BIOPTIC LENS TRAINING THAT INCLUDED DRIVING?
☐ Yes ☐ No ☐ Not Known

Bioptic Telescope ☐ Right eye 20/_____ ☐ Left eye 20/_____
Bioptic Telescope suitable for driving? ☐ Yes ☐ No

SKILL IN USING BIOPTIC TELESCOPE
☐ Satisfactory ☐ Unsatisfactory ☐ Not Known

2. VISUAL ACUITY — Complete Clinical Measurement Section. *Lenses include contact lenses or glasses.*

DMV MEASUREMENT (FOR DMV USE ONLY)				CLINICAL MEASUREMENT (WITHOUT BIOPTIC TELESCOPE)			
	Both Eyes	Right Eye	Left Eye		Both Eyes	Right Eye	Left Eye
Without Lenses	20/	20/	20/	Without Lenses	20/	20/	20/
With Current Lenses	20/	20/	20/	With Lenses	20/	20/	20/
				Best Corrected Visual Acuity	20/	20/	20/

3. DIAGNOSIS — Please indicate vision condition by checking the box(es) representing affected eye(s). If the diagnosed condition is not listed, write the diagnosis under "other diagnosis/comments" below.

REFRACTIVE	R	L
Astigmatism	☐	☐
Hyperopia	☐	☐
Myopia	☐	☐

DEVELOPMENTAL	R	L
Amblyopia	☐	☐
Strabismus	☐	☐
Congenital Nystagmus	☐	☐
Albinism	☐	☐

OPTICAL	R	L
Cataract	☐	☐
Corneal Opacity	☐	☐
Diplopia (uncorrectable)	☐	☐
Keratoconus	☐	☐
Aphakia	☐	☐
Pseudophakia	☐	☐
Post. Caps. Opac.	☐	☐

RETINAL/OPTIC NERVE	R	L
Diabetic Retinopathy	☐	☐
Macular Degeneration	☐	☐
Glaucoma	☐	☐
Retinal Detachment	☐	☐
Retinitis Pigmentosa	☐	☐
Retinal Damage (CRVO, PRP etc.)	☐	☐

VISUAL FIELDS	R	L
Decreased Peripheral Vision	☐	☐
Hemianopia	☐	☐
Quadrantanopia	☐	☐

Decreased Peripheral Vision. Please identify the areas affected on the chart in Section 5 (see reverse)

☐ Other diagnosis/comments _____

☐ Monocular Vision (No Light Perception or Prosthesis) If monocular, when was the monocular vision diagnosed? _____

If monocular, does the patient have a medical condition that could affect the functional eye in the future? ☐ Yes ☐ No

Any eye surgery (including refractive)? ☐ Yes ☐ No Date of most recent surgery _____ Type of surgery _____

Name: DL/ID/X #:

4. PROGNOSIS

Diagnosis _____ ☐ Static ☐ Progressive ☐ Stable since _____ (date)

Diagnosis _____ ☐ Static ☐ Progressive ☐ Stable since _____ (date)

Diagnosis _____ ☐ Static ☐ Progressive ☐ Stable since _____ (date)

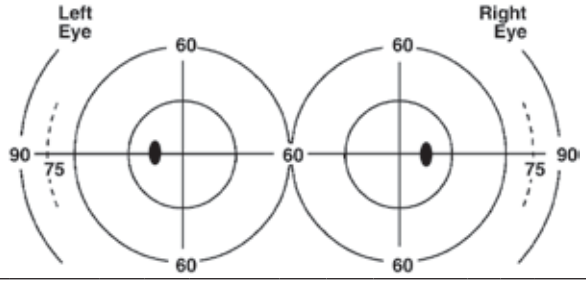
WHEN SHOULD **DMV** REQUIRE A NEW DMV VISION EXAMINATION REPORT FORM BE SUBMITTED?

☐ Not applicable ☐ 1 year ☐ 2 years ☐ 5 years ☐ Other

5. VISUAL FIELDS — If vision is not correctable to 20/40 in each eye, or there is possible visual field loss, a full visual field examination (confrontation is permissible) must be performed. Show the approximate peripheral extent and any **scotomas** in the diagram below.

LEFT EYE

Extent:
Left _____
Right _____
Up _____
Down _____



RIGHT EYE

_____ Extent: Left
_____ Right
_____ Up
_____ Down

6. VISUAL ABNORMALITIES — The following information will help our examiners evaluate your patient's ability to safely operate a motor vehicle. Based upon your testing, clinical impression, or knowledge of the disorder, please indicate the severity of any of the following visual abnormalities which your patient may be experiencing. Indicate severity of condition by placing a 1 (mild), 2 (moderate), or 3 (severe) in the box(es) below.

	R L		R L		R L		R L		R L
Decreased Acuity	☐☐	Visual Field Loss	☐☐	Contrast Sensitivity Loss	☐☐	Problems With Glare	☐☐	Poor Night Vision	☐☐
Color Defect	☐	Reduced Depth Perception	☐	Abnormal Eye Movements	☐				

7. ADVICE — Have you given your patient any advice about driving? ☐ Yes ☐ No If yes, please explain in #8 below.

8. ADDITIONAL COMMENTS — Report any additional information or comments you feel DMV should know concerning your patient's visual and perceptual capabilities relating to driving performance. You may use an additional sheet of paper to provide this information as well as information about any existing conditions which contribute to poor night vision or poor depth perception, etc. Any recommendations about the patient's general safety should also be made. ***DMV will make the final licensing decision based on a combination of factors, including your professional expertise.***

9. SIGNATURE — This section must be completed to validate this report.

PRINTED NAME				M.D. OR O.D. LICENSE NUMBER
SIGNATURE **X**				DATE OF EXAM ***(MUST BE WITHIN LAST 6 MONTHS)***
ADDRESS	CITY	CA	ZIP CODE	TELEPHONE NUMBER ( )