DLAB-2
CDL
Rev. 3/09

STATE OF WEST VIRGINIA
DEPARTMENT OF TRANSPORTATION
DIVISION OF MOTOR VEHICLES

License No. _____ Date _____

Applicant's full name: _____

Street Address _____

City _____ State _____ Zip _____ Date of Birth _____

REPORT ON VISUAL EXAMINATION

Distant Vision Only	Right Eye	Left Eye	Both Eyes		TEST USED
Without Glasses	20 /	20 /	20 /	COORDINATION @ 20 ft. EXO _____ ESO _____ RT. H. _____ LF. H. _____	
				@ 20 ft. EXO _____ ESO _____ RT. H. _____ LF. H. _____	
With Present Glasses	20 /	20 /	20 /	FUSION-DISTANCE EXCELLENT GOOD POOR NONE	TEST USED
With New Prescription	20 /	20 /	20 /	FUSION-NEAR EXCELLENT GOOD POOR NONE	TEST USED
If Possible Measure Above @ 20 Ft. If Not, Please State Dist. Used.				EXCELLENT GOOD POOR NONE	TEST USED
Fields - Horizontal Perception Rt.° Lt.° Total °				COLOR VISION NORMAL DEFICIENT FAIL	TEST USED

To Examining Doctor:

Kindly complete this form. Please leave blank any spaces for test on which you have made no examination. If the case is peculiar, any additional comments on a separate sheet would be appreciated.

IMPORTANT: For proper identification, you will please the person whom you have examined sign the report in your presence.

Sign here: _____

Are corrective lenses needed for distant vision? _____ For near vision? _____ Is there any double vision? _____

If so, is it corrected with glasses or other treatment? _____ Any evidence of eye disease or injury? _____

If so, describe: _____

Can this be corrected or compensated for? _____

Any visual difficulty in seeing in dim light or at night? _____

Does applicant readily distinguish the colors of red, green and amber? _____

Does applicant have diabetic retinopathy? _____

Does applicant have bioptic lenses? _____

In your opinion, does this person have sufficient vision to operate a motor vehicle safely? _____

If yes, should there be any restrictions imposed? _____ If so, what restrictions? _____

Comments: _____

CERTIFICATION OF VISION SPECIALIST

I, _____ being licensed to practice in West Virginia, do certify that I have personally examined the vision of the above named, that a true record of this examination appears on this report and that he or she signed this form in my presence.

Signature of examining doctor: _____

Business address: _____ Date: _____