CERTIFICATE OF VISION EXAMINATION BY COMPETENT AUTHORITY

Wisconsin Department of Transportation
MV3030V/T579 4/2019 Ch. 343 Wis. Stats. and Trans. 112 Admin. Code

Wisconsin Department of Transportation Medical Review
P.O. Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327 FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

APPLICANT: You may be required to file vision reports on a regular basis. We will send you the forms at the time they are required. **Incomplete forms will be returned for completion.**

Applicant Name – First, Middle Initial, Last			
Driver License Number (1 2 3 4 – 5 6 7 8 – 9 10 11 12 – 13 14)		Birth Date (M M – D D – Y Y Y Y)	
Street Address	City	State	ZIP Code
Email Address		(Area Code) Telephone Number	
☐ Yes MV3141 *Driver Condition* or *Behavior Report* is enclosed		Internal WisDOT Use ONLY Issued by: Date:	Other Type ☐ Behav ☐ Board ☐ Waiver
License Applied For ☐ Class D ☐ Class M ☐ CDL ☐ School Bus ☐ Passenger			

Minimum Standards see: http://wisconsindmv.gov/vision

VISION SPECIALIST: The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver licensing. Your report will be advisory in determining eligibility.

Indicate Snellen Chart Figures

Visual Acuity	Without RX	With RX	Temporal Field of Vision In Degrees
Right Eye	20/	20/	
Left Eye	20/	20/	

This report must be completed based on an examination conducted within the past 90 days or since: _____

YES	NO		
☐	☐	1.	Does applicant have progressive eye condition(s)? ____OD ____OS ____OU If yes, what?
☐	☐	2.	Is applicant able to distinguish traffic signal colors of red, amber and green?
		3.	Would you recommend:
☐	☐		Corrective lenses
☐	☐		No freeway or interstate highway
☐	☐		Limited radius driving. Miles from home: _____
☐	☐		Daylight driving ONLY
☐	☐		Other: _____
☐	☐	4.	Would you recommend a driving evaluation with DMV (knowledge, signs and road test)?
		5.	Do you feel the patient is safe to operate the following: (any recommendations are strictly advisory)
☐	☐		Non-Commercial Vehicle
☐	☐		Commercial Vehicle
☐	☐		School and/or Passenger Bus
☐	☐	6.	If applicable, I reviewed the attached Driver Condition or Behavior Report
☐	☐	7.	Do you recommend any additional medical evaluation?

Comments: _____

Specialist – Print Name	Check One: ☐ MD ☐ DO ☐ OD ☐ PA-C ☐ APNP	Medical License Number
Office Address, City, State, ZIP Code		(Area Code) Office Telephone Number
X (Specialist – Signature)	(Date – m/d/yyyy)	Patient Exam Date (m/d/yyyy)

Pursuant to s.448.01 and s.449.01 Wis. Statutes and Trans Ch. 112.02 Wis. Admin. Code, this form must be signed by an MD, DO, OD, PA-C or APNP.