WASHINGTON STATE DEPARTMENT OF LICENSING

Visual Examination Report

You can use this form to provide us with information regarding a driver's ability to safely operate a motor vehicle.

Driver – Complete this section and sign the consent to release information. Have your ophthalmologist or optometrist complete this form. The ophthalmologist/optometrist will send the completed form to us.

Name *(Last, First, Middle)*		Date of birth	Today's date
(Area code) Daytime telephone number	(Area code) Home telephone number	Driver license number	

Consent to release information

I authorize _____, an ophthalmologist/optometrist, to provide clarification or information regarding my visual condition ***based on an examination conducted within the past year****. I understand the Department of Licensing will use this information to arrive at a decision regarding my ability to safely operate a motor vehicle.*

X _____ Driver signature

X _____ Signature of parent (if minor)

Ophthalmologist/Optometrist – Please complete the following and mail to: **Medical Unit, Department of Licensing, PO Box 9030, Olympia, WA 98507** or fax to **(360) 570-7893**.

	Without correction			With correction		
	Right 20/	Left 20/	Both 20/	Right 20/	Left 20/	Both 20/
1. This individual's best attainable visual acuity is						

If this individual's vision is not at least 20/70 Snellen range with correction, they will be deemed to have failed to demonstrate that they are qualified to drive at night and will be restricted to daylight driving only.
Comments: _____

2. Is this individual's visual acuity correction achieved by use of devices other than contact lenses or external spectacles? ☐ Yes ☐ No
If yes, please explain: _____

3. **Field of vision:** Is this individual's total visual field less than 110 degrees in horizontal meridian with a test object of 3mm/330mm white or a comparable field with comparable target? . . . . . ☐ Yes ☐ No
If yes: Temporal Nasal Temporal Nasal
a) Visual field is: . . . . . Right _____ Left _____
b) Is test performed by hand held confrontation? . . . . . ☐ Yes ☐ No
Comments: _____

4. Does this individual have subjective diplopia? . . . . . ☐ Yes ☐ No
If yes, explain the degree of compensation: _____

5. Should this individual be required to submit periodical visual reports as a condition of licensing? . . . . . ☐ Yes ☐ No
If yes, how often? ☐ 6 months ☐ 1 year ☐ 2 years
Comments: _____

Ophthalmologist/Optometrist name	Professional license number	(Area code) Telephone number	Exam date
Street address	City	State	ZIP code

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

_____ Date and place signed

X _____ Signature of ophthalmologist/optometrist

If this Department has reason to believe that a person is suffering from a physical or mental disability or disease that may affect that person's ability to drive a motor vehicle, we must evaluate whether the person is able to safely drive. As part of the evaluation, we may require the person to obtain a statement signed by a licensed physician or other proper authority designated by us, certifying the person's condition. RCW 46.20.041; 46.20.305.

We are committed to providing equal access to our services.
If you need accommodation, please call (360) 902-3900 or TTY (360) 664-0116.