STATE OF DELAWARE DIVISION OF MOTOR VEHICLES

REPORT OF VISUAL STATUS BY AN OPTOMETRIST OR OPHTHALMOLOGIST

NAME OF APPLICANT _____D.O.B ___/___/_____ D.L.#_____

ADDRESS_____DATE ___/___/_____

DIVISION LOCATION P.O. BOX 698 DOVER, DE 19903 (302)744-2507

VISUAL ACUITY	NO R/	WITH R/	
R.E	20/	20/	□Contact Lens
L.E.	20/	20/	□Glasses
B.E.	20/	20/	

WOULD DRIVER'S VISUAL ABILITIES BE IMPROVED BY CORRECTIVE LENSES? _____

DESCRIBE ANY FIELD DEFFECT: _____

IS THERE ANY EVIDENCE OF EYE DISEASE OR DEFECT OF STRUCTURE THAT WOULD AFFECT VISUAL PERFORMANCE NOW OR IN THE FUTURE?

IN THE CAUSE OF SAFETY, ARE THERE ANY RESTRICTIONS THAT SHOULD BE IMPOSED ON LICENSE? □ YES □ NO

□ CORRECTIVE LENSES

□ DAYLIGHT DRIVING ONLY

WITH REGARD TO DRIVING, HOW OFTEN SHOULD APPLICANT HAVE VISION CHECKED?

□ 6 MOS.□ 1 YR.□ 2 YRS.□ 3YRS. □ 4 YRS. □ CLOSE DMV CASE

ARE THER ANY CIRCUMSTANCES THAT MIGHT BE EXPLAINED TO AID FINAL DISPOSITION OF THIS CASE?

REMARKS:

I HEREBY CERTIFY THAT I'M LICENSED TO PRACTICE:

_____ _____
IN THE STATE OF LIC OR REC NO

_____
NAME AND DEGREE-PLEASE PRINT

_____
ADDRESS

_____
SIGNATURE AND DATE

PRESCRIPTION BLANK OR STATEMENT OF EXAMINING DOCTOR MUST BE INCLUDED WITH THIS REPORT. MAIL TO EXAMINER AT THIS LOCATION. (DO NOT RETURN TO APPLICANT)

20/40 UNRESTRICTED 20/50 DAYLIGHT DRIVING ONLY BELOW 20/60- LICENSE DENIED

DMV FAX: 302-739-5667

EMAIL: DMVMEDICALSECTION@DELAWARE.GOV