Eye Evaluation

☐ Complete Date: _____
☐ Incomplete Date: _____
Comments:

PLEASE PRINT P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-3933 • Fax (406) 444-1631 • DriverLicense@mt.gov • dojmt.gov

*Indicates a Section or Field. Please PRINT

Patient's Legal Last Name*	Patient's Legal First Name*		Driver License Number
Mailing Address	City	State	Zip
Email Address	Phone Number*		Date of Birth*

EXPLANATION FOR EYE SPECIALIST

The Motor Vehicle Division requires information to verify a driver meets Montana vision standards for the purpose of driver license issuance. This form must be completed by an eye specialist. The eye specialist assumes no responsibility in making this report other than that of precisely representing the facts.
Please complete this form for the examination you conduct. Attach a separate sheet if the case is unique and additional comments are necessary. For proper identification, have the driver sign the report in your presence.

RELEASE OF INFORMATION BY DRIVER – SIGN IN PRESENCE OF EYE SPECIALIST

I authorize my eye specialist to answer any questions from the Motor Vehicles Division or its employees relating to my physical or medical condition and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana.

I authorize the Motor Vehicle Division to receive any information relating to my physical or medical condition and to use the same in determining whether I have the ability to safely operate a motor vehicle.

Signed: _____ Date: _____

Vision Test:	Without Correction:*	With Correction:*	With New RX
Both Eyes	20/	20/	20/
Left Eye	20/	20/	20/
Right Eye	20/	20/	20/

BREADTH OF VISION FIELD (*Required for CDL Drivers)

To Right of Point of Fixation _____ To Left Point of Fixation _____

Total Angle _____

Are you fitting for new corrective lenses? ☐ Yes ☐ No Type of Instrument used to determine visual acuity: ☐ System ☐ Snellen Chart

Is there double vision? ☐ Yes ☐ No If yes, describe: _____

Can the double vision be corrected with corrective lenses? ☐ Yes ☐ No ☐ N/A

Is there evidence of eye disease or injury resulting in vision impairment? ☐ Yes ☐ No If yes, describe: _____

Are there any known problems with night vision? ☐ Yes ☐ No If yes, describe: _____

Does the patient have red, green, or amber color deficiencies? ☐ Yes ☐ No If yes, explain: _____

Does the patient have a vision condition that requires monitoring by MVD? ☐ Yes ☐ No

If yes, how often do you recommend monitoring? ☐ 6 months ☐ 1 year ☐ 2 years ☐ _____ Years

CERTIFICATION OF EYE SPECIALIST

Print Name*	Type of Practice of Medical Specialty*	Medical License Number*
Address	Email	Phone Number*
Signature*		Date*