DL-102 (4-22)

pennsylvania
DEPARTMENT OF TRANSPORTATION

REPORT OF EYE EXAMINATION

To be completed by an optometrist, ophthalmologist, physician assistant, certified registered nurse practitioner, or licensed physician with equipment to properly evaluate vision

Bureau of Driver Licensing • P.O. Box 68682 • Harrisburg, PA 17106-8682 • (717) 787-9662
Return this form to the address listed above, FAX to (717) 705-4415, or email to Medical@pa.gov.

THIS FORM HAS BEEN APPROVED BY THE MEDICAL ADVISORY BOARD **For Official PennDOT Use Only**

PROVIDER: For more information relating to Medical Reporting, visit www.dmv.pa.gov and click on the Medical Reporting tab under Information Centers.

PATIENT INFORMATION Are you a CDL driver? ❑ YES ❑ NO

DRIVER'S LICENSE NO.	LAST NAME(S)	JR. ETC	FIRST NAME

HEIGHT		SEX	EYE COLOR	DATE OF BIRTH			TELEPHONE NUMBER	E-MAIL ADDRESS: (if applicable)
FEET	INCHES			MONTH	DAY	YEAR		

STREET ADDRESS: P.O. Box number may be used in addition to the actual address, but cannot be used as the only address.	CITY	STATE	ZIP CODE

REGULAR DRIVER (CLASS A, B, C & M)

UNCORRECTED
R 20/
L 20/
B 20/

CORRECTED
R 20/
L 20/
B 20/

1. Do you consider this person visually capable to drive? . . . . . ❑ YES ❑ NO
2. Is individual's combined field of vision at least 120° in the horizontal meridian, excepting the normal blind spots? . . . . . ❑ YES ❑ NO
3. Must individual wear corrective lenses? . . . . . ❑ YES ❑ NO
4. Is correction obtained through telescopic lenses? (If yes, please complete form DL-102BD) . . . . . ❑ YES ❑ NO
5. Does this individual's condition warrant monitoring by the Department? . . . . . ❑ YES ❑ NO

   If so, how often? _____

SCHOOL BUS DRIVERS (S ENDORSEMENT):

1. Individual has distant visual acuity of at least 20/40 in the BETTER eye without corrective lenses or visual acuity corrected to 20/40 or better? . . . . . ❑ YES ❑ NO
2. Individual has at least 20/50 in the POORER eye without corrective lenses or visual acuity corrected to 20/50 or better?. . . . . ❑ YES ❑ NO
3. Individual has distant binocular acuity of at least 20/40 in both eyes with or without corrective lenses? . . . ❑ YES ❑ NO
4. Is individual's combined field of vision at least 160^0 in the horizontal meridian, excepting the normal blind spots? . . . . . ❑ YES ❑ NO
5. Individual has the ability to determine colors used in traffic signals and devices showing standard red, green or amber. . . . . ❑ YES ❑ NO
6. Individual must wear corrective lenses . . . . . ❑ YES ❑ NO
7. Has the patient had an annual dilated eye exam? If Yes, Date of Exam:_____/_____/_____ . . . . . ❑ YES ❑ NO

   What were the results?

   ❑ No diabetic retinopathy was detected.
   ❑ Background retinopathy was detected, but only requires monitoring. No treatment is indicated.
   ❑ Retinopathy requiring further testing and/or treatment was detected.

HEALTH CARE PROVIDER'S INFORMATION (Please print or type)

HEALTH CARE PROVIDER'S NAME	SPECIALTY	HEALTH CARE PROVIDER'S LICENSE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TELEPHONE NUMBER	FAX NUMBER		

I hereby state that the facts above set forth are true and correct to the best of my knowledge, information and belief. I understand that the statements made herein are made subject to the penalties of 18 Pa. C.S. § 4904 (relating to unsworn falsification to authorities) punishable by a fine up to $2,500 and/or imprisonment up to 1 year.

_____ Health Care Provider's Signature

_____ Date