DL-102BD (9-21)

pennsylvania
DEPARTMENT OF TRANSPORTATION

BIOPTIC LENS VISION EXAMINATION

To be completed by an Optometrist or Ophthalmologist prescribing the bioptic telescopic lens.

Bureau of Driver Licensing • P.O. Box 68682 • Harrisburg, PA 17106-8682 • (717) 787-9662 • medical@pa.gov

THIS FORM APPROVED BY THE MEDICAL ADVISORY BOARD

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

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

UNCORRECTED	CORRECTED	CORRECTED w/BIOPTICS
R 20/	R 20/	R 20/
L 20/	L 20/	L 20/
B 20/	B 20/	B 20/

CHECK ONE: YES NO

1. Does the patient have at least 20/200 visual acuity in the best corrected eye? . . . . . ❑ ❑

2. Is the patient's combined field of vision at least 120° in the horizontal meridian, excepting the normal blind spots? . . ❑ ❑

3. Does the patient have color vision sufficient to respond correctly to the presence of, or changes in, traffic light color, pavement markings, road signs, turn indicators, brake lights, emergency flashers or the presence of other road users, including emergency vehicles? . . . . . ❑ ❑

4. Is the patient's bioptic telescope correction no greater than a 6X telescope and firmly fixed in the glasses or attached permanently to the bridge of the frame? . . . . . ❑ ❑

5. On which lens is the bioptic telescope mounted? ❑ Left ❑ Right ❑ Both

6. What is the power of the bioptic telescope? _____

7. Has the patient held physical possession of their prescription bioptic lens for at least three months? . . . . . ❑ ❑
   On what date did the patient receive their bioptic lens? _____

8. How long has this patient been under your care? _____

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