

**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

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">VISUAL ACUITY</td> <td style="width:15%;">NO R/</td> <td style="width:15%;">WITH R/</td> <td style="width:55%;"></td> </tr> <tr> <td>R.E.</td> <td>20/</td> <td>20/</td> <td><input type="checkbox"/> Contact Lens</td> </tr> <tr> <td>L.E.</td> <td>20/</td> <td>20/</td> <td><input type="checkbox"/> Glasses</td> </tr> <tr> <td>B.E.</td> <td>20/</td> <td>20/</td> <td></td> </tr> </table>	VISUAL ACUITY	NO R/	WITH R/		R.E.	20/	20/	<input type="checkbox"/> Contact Lens	L.E.	20/	20/	<input type="checkbox"/> Glasses	B.E.	20/	20/		<p>IS THERE ANY EVIDENCE OF EYE DISEASE OR DEFECT OF STRUCTURE THAT WOULD AFFECT VISUAL PERFORMANCE NOW OR IN THE FUTURE?</p> <p>IN THE CAUSE OF SAFETY, ARE THERE ANY RESTRICTIONS THAT SHOULD BE IMPOSED ON LICENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> CORRECTIVE LENSES</p> <p><input type="checkbox"/> DAYLIGHT DRIVING ONLY</p>
VISUAL ACUITY	NO R/	WITH R/															
R.E.	20/	20/	<input type="checkbox"/> Contact Lens														
L.E.	20/	20/	<input type="checkbox"/> Glasses														
B.E.	20/	20/															
<p>WOULD DRIVER'S VISUAL ABILITIES BE IMPROVED BY CORRECTIVE LENSES? _____</p> <p>DESCRIBE ANY FIELD DEFFECT: _____</p>	<p>I HEREBY CERTIFY THAT I'M LICENSED TO PRACTICE:</p> <p>_____</p> <p>IN THE STATE OF _____ LIC OR REC NO _____</p> <p>_____</p> <p align="center">NAME AND DEGREE-PLEASE PRINT</p> <p>_____</p> <p align="center">ADDRESS</p> <p>_____</p> <p align="center">SIGNATURE AND DATE</p> <p>PRESCRIPTION BLANK OR STATEMENT OF EXAMINING DOCTOR MUST BE INCLUDED WITH THIS REPORT. MAIL TO EXAMINER AT THIS LOCATION. (DO NOT RETURN TO APPLICANT)</p>																
<p>WITH REGARD TO DRIVING, HOW OFTEN SHOULD APPLICANT HAVE VISION CHECKED?</p> <p><input type="checkbox"/> 6 MOS. <input type="checkbox"/> 1 YR. <input type="checkbox"/> 2 YRS. <input type="checkbox"/> 3 YRS. <input type="checkbox"/> 4 YRS. <input type="checkbox"/> CLOSE DMV CASE</p> <p>ARE THER ANY CIRCUMSTANCES THAT MIGHT BE EXPLAINED TO AID FINAL DISPOSITION OF THIS CASE?</p> <p>REMARKS:</p>																	

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

DMV FAX: 302-739-5667

EMAIL: DMVMEDICALSECTION@DELAWARE.GOV