TENNESSEE DEPARTMENT OF SAFETY AND HOMELAND SECURITY VISION EXAMINATION FORM

Important information for Driver Applicant

The vision screening by a Driver License Examiner indicates there is a possible vision impairment that would affect your ability to safely operate a motor vehicle. You are being asked to have your vision checked by a licensed eye care Doctor of Optometry or Doctor of Ophthalmology to determine whether your vision can be improved by eye glasses or eye treatment.

If you have any questions about how well you must be able to see to drive on the streets and highways of Tennessee, the Driver's License Examiner will be glad to assist you.

Driver License Examiners are prohibited from referring you to or recommending the name of an eye specialist.

When you return to the Driver Service Center after your eye examination, you must bring this completed form by your eye doctor, along with any new eye glasses or corrective lenses.

FOR DOCTOR OF OPTOMETRY OR OPHTHALMOLOGY ONLY

Important information for the Eye Care Provider

All applicants for a driver license as well as drivers whose record cast doubt on their ability to drive safely, are given vision screenings by the Driver License Examiners. When this screening indicates that a vision examination is needed by an eye care professional, the person is asked to visit a vision specialist.

Upon completion of your eye examination of the driver applicant, please completely fill out this form and certification. Please have patient sign this form in your presence.

No recommendations or suggestions are given by the Tennessee Department of Safety and Homeland Security Driver License Examiners as to which eye specialist to visit. This report can only be accepted from a licensed Doctor of Optometry or Doctor of Ophthalmology.

Full Name of Person Examined: ____
First Middle Last Name

Street Address: ______________________ City ______________________ State ________ Zip Code __________

ACUITY	RIGHT EYE	LEFT EYE	BOTH EYES	FIELD OF VISON
WITH PRESENT GLASSES (IF ANY)	20/	20/	20/	TO RIGHT OF POINT OF FIXATION
WITHOUT GLASSES	20/	20/	20/	TO LEFT OF POINT OF FIXATION
WITH BEST POSSIBLE CORRECTION	20/	20/	20/	TOTAL ANGLE
COLOR TEST				

(OVER)

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1. Are glasses needed for distant vision? ________________ Are they being prescribed or fitted? ______________
2. Describe any irregularities such as : Double vision, poor night vision, eye injury, eye disease, poor near vision, etc:

____

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3. Will eye glasses improve conditions described in Question 2 above? ______________________________
4. Will other treatments improve above-described conditions for the eyes? ______________________________

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5. Is the person named in this report currently undergoing the recommend treatment to improve vision? __________
6. Additional Comments:

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CERTIFICATION OF OPHTHAMOLOGIST OR OPTOMETRIST

I, ____, being licensed to practice in the specialty of eye care, in the State of ________________________________, certify I have personally examined the eyes of the above named. A true record of this examination appears on this report and he or she signed below in my presence.

Signature of Examining Doctor ________________________________ DATE ______________

Medical License Number ________________________________ STATE ______________

Office Address ____ City ____________________

STATE ____________ ZIP CODE ____________ Office Telephone Number ____________________

Signature of Person Receiving Eye Examination ________________________________ DATE ______________