

Visual Examination Report

Failure to complete and return this form within 30 days from: 24-Apr-2025 may result in **suspension of your driver license.**

Driver/Patient Information

Name (Last, First, Middle)			
Date of birth	(Area code) Daytime telephone number	Driver license number WDL439P8703B	
Consent to release information <i>I authorize the ophthalmologist/optometrist below to provide clarification or information regarding my visual condition based on an examination conducted within the past year. I understand the Department of Licensing will use this information to arrive at a decision regarding my ability to safely operate a motor vehicle.</i>			
Driver signature	Date	Signature of parent (if minor)	Date

Ophthalmologist/Optometrist ONLY

DOL has reason to believe the driver named above may have a condition that could affect the safe operation of a motor vehicle.

Your knowledge of this person's condition is of great value in assisting us determine a proper licensing decision. **DOL has sole responsibility for any decision** regarding driving qualifications and licensure. **Answer ALL questions** and return to DOL.

Date of examination (within past year)	Without correction			With correction		
	Right	Left	Both	Right	Left	Both
	20/	20/	20/	20/	20/	20/

- This individual's best attainable visual acuity is
Vision that is not at least 20/70 Snellen range with correction is deemed unqualified to drive at night.
- Was testing done with a visual acuity correction device (bioptic/telescopic lens)? Yes No
- Field of vision:** Is this individual's total visual field less than 110 degrees in horizontal meridian with a 3mm test object/330mm white background or with a comparable target and field? Yes No
 - If "Yes", visual field is: Left temporal _____ degrees Right temporal _____ degrees
 - If "Yes", have you noticed a decline in the field of vision in the last 12 months? Yes No
- Does this individual have subjective diplopia and were they tested for it? Yes No
- Should the DOL monitor this driver's condition with periodical visual examination reports? Yes No
If "Yes", how often? 6 months 1 year 2 years

Comments/Other conditions that may affect this person's driving:

Ophthalmologist/Optometrist name	Professional license number	
Address (Street Address, City, State, ZIP code)		
(Area code) Telephone number	(Area code) Fax number	Email

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct

Date	Place (city or county) signed	Signature (Ophthalmologist/Optometrist ONLY)
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