

Vision Screening Form

This form may be used to record:

- MVA's vision screening results, if the screening has taken place
- Your vision specialist's examination results

Driver/Patient's full name: _____

Driver/Patient's Maryland driver's license number: _____

MVA Vision Screening Results: Findings from MVA's Vision Screening (For MVA use only)

	Right Eye	Left Eye	Both Eyes	Field of Vision Continuous?	Color vision problems?	MVA employee:
Acuity without lenses	20/	20/	20/			
Acuity with present lenses	20/	20/	20/	<input type="checkbox"/> yes	<input type="checkbox"/> yes	MVA office:
Field of Vision (degrees)	degrees	degrees	degrees	<input type="checkbox"/> no	<input type="checkbox"/> no	Date:

Vision Specialist's Examination Results and Certification

Vision Exam Date: _____ Diagnosis, if applicable: _____

	Right Eye	Left Eye	Both Eyes	Binocular Vision?	Please Note: The Snellen test must be used
Acuity without lenses	20/	20/	20/		
Acuity with present lenses	20/	20/	20/	<input type="checkbox"/> yes <input type="checkbox"/> no	Please do not enter acuities achieved by telescopic lenses in this chart.
Acuity with best standard spectacle correction	20/	20/	20/		
Field of Vision (in degrees)	degrees	degrees	degrees		

• Are corrective lenses (standard spectacle) needed to meet vision requirements for driving? yes no

If corrected lenses are needed, has this patient acquired the lenses? yes no

• Will treatment improve this patient's vision for driving? yes no

If yes, please describe: _____

• Does this patient meet the continuous field of vision requirements specified by the MVA? yes no

• Did the visual examination reveal any optical or medical reason that could preclude granting a license? yes no
 (If yes, please submit a complete report for the MVA's Medical Advisory Board.)

• For commercial licenses only: Can this patient distinguish between red, green and amber colors? yes no

Even if this individual is presently eligible to renew by mail, I understand I may contact the Medical Advisory Board for follow-up if I later detect any change in visual acuity that may affect fitness to drive.

I certify under penalty of perjury that the information contained hereon is true and accurate to the best of my knowledge, information and belief.

Ophthalmologist/Optomestrist's Signature _____ Printed Name _____ Date _____

Licensed to practice: Medicine Ophthalmology Optometry in the state of : _____

Ophthalmologist/Optomestrist's Address _____ Phone Number _____