Click here to START or CLEAR, then hit the TAB button

WASHINGTON STATE DEPARTMENT OF LICENSING

Visual Examination Report

Mail or fax completed report to:
Restricted Licensing
Department of Licensing
PO Box 9030
Olympia, WA 98507
Fax: **(360) 570-7893**
Email: **MedicalCerts@dol.wa.gov**

Failure to return this completed form by _____ to Department of Licensing (DOL) may result in the suspension of the driver's driving privilege.

Driver/Patient information

Name *(Last, First, Middle)*

Date of birth	(Area code) Daytime telephone number	Driver license number

Consent to release information

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.*

X **Driver: When completed, print this out and sign and date here.**
Driver signature Date

X **Parent: When completed, sign and date here.**
Signature of parent (if minor) Date

Ophthalmologist/Optometrist

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

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 20/	Left 20/	Both 20/	Right 20/	Left 20/	Both 20/
1. 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.

2. Was testing done with a visual acuity correction device: bioptic/telescopic lens? ☐ Yes ☐ No
3. Field of vision: Is this individual's total visual field less than 110 degrees in horizontal meridian with a test object? ☐ 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
4. Does this individual have subjective diplopia and was tested for it? ☐ Yes ☐ No
   If "Yes", how is the compensation achieved? _____
5. Should DOL monitor this driver's condition with periodic 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 information I have provided is true and correct.

Date Place (city or county) signed

X **Ophthalmologist/Optometrist, sign here when completed.**
Ophthalmologist/Optometrist signature

RCW 46.20.041; 46.20.305