

Envíe el informe completo por correo o fax a:
Restricted Licensing
Department of Licensing
PO Box 9030
Olympia, WA 98507
 Fax: (360) 570-7893
 Correo electrónico:
MedicalCerts@dol.wa.gov

Si no devuelve este formulario completo antes del _____ al Department of Licensing (DOL), puede ocasionar la suspensión del derecho a conducir del conductor.

Información del conductor o paciente		
Nombre (apellido, primer nombre, segundo nombre)		
Fecha de nacimiento	(Código de área) número de teléfono durante el día	Número de licencia de conducir
Consentimiento para revelar información Autorizo al oftalmólogo/optometrista mencionado debajo a brindar aclaraciones o información acerca de la condición de mi vista con base en el examen que se me realizó el año pasado . Entiendo que el Department of Licensing utilizará esta información para tomar una decisión acerca de mi habilidad para operar con motores de vehículos de manera segura.		
X		X
Firma del conductor	Fecha	Firma del padre o de la madre (en caso de menores)
		Fecha

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.															
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)	<table border="1"> <tr> <th colspan="3">Without correction</th> <th colspan="3">With correction</th> </tr> <tr> <td>Right 20/</td> <td>Left 20/</td> <td>Both 20/</td> <td>Right 20/</td> <td>Left 20/</td> <td>Both 20/</td> </tr> </table>			Without correction			With correction			Right 20/	Left 20/	Both 20/	Right 20/	Left 20/	Both 20/
Without correction			With correction												
Right 20/	Left 20/	Both 20/	Right 20/	Left 20/	Both 20/										
Answer the following															
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? <input type="checkbox"/> Yes <input type="checkbox"/> No															
3. Field of vision: Is this individual's total visual field less than 110 degrees in horizontal meridian with a test object? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No															
4. Does this individual have subjective diplopia and was tested for it? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how is the compensation achieved? _____															
5. Should DOL monitor this driver's condition with periodic Visual Examination Reports? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", how often? <input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 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 signature