Haga clic aquí para INICIAR o BORRAR, luego presione el botón TAB

WASHINGTON STATE DEPARTMENT OF LICENSING

Informe del examen de la vista

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

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

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 **Conductor: Cuando esté completo, imprímalo, firme y coloque la fecha aquí.**
Firma del conductor Fecha

X **Padre/madre: Cuando esté completo, firme y coloque la fecha aquí.**
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. 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/

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? . . . . . ☐ 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