STATE OF DELAWARE DIVISION OF MOTOR VEHICLES
REPORT OF VISUAL STATUS BY AN OPTOMETRIST OR OPHTHALMOLOGIST

NAME OF APPLICANT _____ D.O.B. ____/____/____ D.L. # _____

ADDRESS _____ DATE ____/____/____

DIVISION LOCATION _____

VISUAL ACUITY	NO R/	WITH R/
R.E.	20/	20/
L.E.	20/	20/
B.E.	20/	20/

❑ CONTACT LENS
❑ GLASSES

WOULD DRIVER'S VISUAL ABILITIES BE IMPROVED BY CORRECTIVE LENSES? _____

ARE THEY BEING PRESCRIBED? _____

DESCRIBE ANY FIELD DEFECT: _____

IS THERE ANY EVIDENCE OF EYE DISEASE OR DEFECT OF STRUCTURE THAT WOULD AFFECT VISUAL PERFORMANCE NOW OR IN THE FUTURE?

IN THE CAUSE OF SAFETY, ARE THERE ANY RESTRICTIONS THAT SHOULD BE IMPOSED ON LICENSE? ❑ YES ❑ NO

❑ CORRECTIVE LENSES
❑ DAYLIGHT DRIVING ONLY

WITH REGARD TO DRIVING, HOW OFTEN SHOULD APPLICANT HAVE VISION CHECKED?

❑ 1 YR. ❑ 2 YRS. ❑ 3 YRS. ❑ 4 YRS.

ARE THERE ANY CIRCUMSTANCES THAT MIGHT BE EXPLAINED TO AID FINAL DISPOSITION OF THIS CASE?

REMARKS:

I HEREBY CERTIFY THAT I'M LICENSED TO PRACTICE:

_____

IN THE STATE OF: _____ LIC OR REC NO.: _____

_____
NAME AND DEGREE - PLEASE PRINT

_____
ADDRESS

_____
SIGNATURE AND DATE

PRESCRIPTION BLANK OR STATEMENT OF EXAMINING DOCTOR ***MUST*** BE INCLUDED WITH THIS REPORT. MAIL TO EXAMINER AT HIS LOCATION.

(DO NOT RETURN TO APPLICANT)

20/40 UNRESTRICTED 20/50 DAYLIGHT DRIVING ONLY BELOW 20/50 - LICENSED DENIED

DMV FAX #
302-739-5667
OR EMAIL TO:
DMVMEDICALSECTION@DELAWARE.GOV