VISION SPECIALIST'S STATEMENT OF EXAMINATION

Michigan Department of State
Driver Assessment and Appeal Division

INSTRUCTIONS FOR DRIVER/APPLICANT

The Department of State is seeking information to determine if you have a visual condition that may affect your ability to drive safely. This request is based on results of a vision screening at a Secretary of State office or other information received by the department. **Please complete Sections 1 and 2** and then have your vision specialist complete the other sections. Either you or your vision specialist may return the completed form to the department. Failure to have this form completed and returned may result in the suspension of your driver's license or the denial of your license application. Information provided in this statement must be based on a vision examination completed within the last six months. Payment for any examination and the preparation of this form is your responsibility. The decision to grant, suspend or reinstate an individual's driving privileges rests solely with the Department of State, which may consider other facts or conditions when making this decision.

INSTRUCTIONS FOR VISION SPECIALIST

The Department of State is seeking assistance in determining the visual condition of this patient. Your professional opinion, the answers to these questions, and any other pertinent information will help the department assess this individual's ability to safely operate a motor vehicle. After the patient has completed Sections 1 and 2, please complete Sections 3 through 7. If you need additional information, please contact the department at (517) 335-7051. Either you or your patient may return the completed form to the department.

SECTIONS 1 AND 2 TO BE COMPLETED BY DRIVER/APPLICANT

SECTION 1: GENERAL INFORMATION

(Please print or type)

Name (First, Middle, Last)	Date of Birth	Driver's License Number	
Street Address		Telephone Number 8 a.m. – 5 p.m.	
City	State	ZIP	Today's Date

I authorize the release of information to the Department of State only for the purpose of assisting in evaluating my ability to safely operate a motor vehicle. I certify that my responses contained in this document are true and accurate to the best of my knowledge and belief.

Driver/Applicant's Signature: _____

Please complete the following information if you assisted the driver/applicant with the completion of this form.

Name _____ Telephone Number _____

Address _____

I am completing Sections 1 and 2 of this form at the request of the driver/applicant.

Signature: _____ Relationship to Driver/Applicant: _____ Date:_____

Please mail, fax, or e-mail to:

Michigan Department of State
Driver Assessment and Appeal Division
P.O. Box 30196, Lansing, Michigan 48909-7696
Phone: (517) 335-7051; Fax: (517) 335-2189; E-mail: medicalforms@michigan.gov
www.Michigan.gov/sos

SECTION 2: QUESTIONS FOR DRIVERS

Failure to truthfully and completely respond to all questions may result in withdrawal of driving privileges.

1. Do you have difficulty with daylight driving or reading road signs? ☐ Yes ☐ No
2. Do you have difficulty seeing at night? ☐ Yes ☐ No
3. Do headlights from other vehicles significantly interfere with your vision at night? ☐ Yes ☐ No
4. Has any family member, friend, physician or police officer made a suggestion that you not drive or limit your driving? ☐ Yes ☐ No
5. How many accidents have you had while driving in the past 5 years? _____ ☐ None
6. Please list all prescribed medications you are currently taking: ☐ None

   _____

   _____

   _____

7. Do you require a passenger to assist you when driving? ☐ Yes ☐ No
8. Were you advised to obtain glasses? ☐ Yes ☐ No
9. When was your last eye exam? _____

   Were you given a prescription for new corrective lenses? ☐ Yes ☐ No

   If yes, when did you receive them? _____

   From whom did you receive them (name, address, and telephone number)? _____

   _____

10. Do you use a special adaptive device while driving such as a bioptic telescopic lens? ☐ Yes ☐ No

    If yes, please answer the following questions:

    What device do you use? _____

    How long have you used it for driving? _____

    Have you received any training to use it? ☐ Yes ☐ No

    If yes, when? _____

    From whom did you receive training (name, address, and telephone number)? _____

    _____

SECTIONS 3 THROUGH 7 TO BE COMPLETED BY VISION SPECIALIST

SECTION 3: VISUAL ACUITY

(Please print or type)

1. Is this your first visit with this patient? ☐ Yes ☐ No

   If no, when did you first see the patient? _____

2. Date of most recent visual exam: _____

3. Visual Acuity:

	Right Eye	Left Eye	Both Eyes
Uncorrected	20/	20/	20/
With Present Corrective Lens	20/	20/	20/
With New Prescription	20/	20/	20/
Contrast Sensitivity (optional)	20/	20/	20/

4. Did you give the patient a new prescription for corrective lenses? ☐ Yes ☐ No

5. Does this patient require a bioptic telescopic device to operate a motor vehicle? ☐ Yes ☐ No

   If yes, visual acuity:

	Right Eye	Left Eye	Both Eyes
With Present Carrier Lens	20/	20/	20/

   What is the patient's visual acuity through the bioptic telescopic lens? __20/_____

   What is the power of the patient's bioptic telescopic device? _____

SECTION 4: PERIPHERAL VISION

1. Horizontal fields in degrees for both eyes:
   - ☐ Less than 90 degrees
   - ☐ 90 degrees to less than 110 degrees
   - ☐ 110 degrees or greater

2. Do you suspect a visual field defect? ☐ Yes ☐ No

   If yes, please explain how it may affect the patient's ability to drive safely: _____

   _____

SECTION 5: OCULAR DIAGNOSES

(Please attach additional pages if necessary)

Primary Diagnosis:	**Secondary Diagnosis:**	**Tertiary Diagnosis:**
Permanent ☐ Yes ☐ No	Permanent ☐ Yes ☐ No	Permanent ☐ Yes ☐ No
Progressive ☐ Yes ☐ No	Progressive ☐ Yes ☐ No	Progressive ☐ Yes ☐ No
Capable of improvement ☐ Yes ☐ No	Capable of improvement ☐ Yes ☐ No	Capable of improvement ☐ Yes ☐ No
Comments:	Comments:	Comments:

SECTION 6: GENERAL QUESTIONS FOR VISION SPECIALIST

1. What driving restrictions, if any, do you recommend based upon your patient's vision condition(s)?
   ☐ Adaptive equipment ☐ Daylight driving only ☐ No expressway driving ☐ Other _____

   Comments: _____

2. Do you have any of the following concerns regarding the patient's capability to safely operate a motor vehicle?

Visual	☐ Yes	☐ No	Psychological	☐ Yes	☐ No
Cognitive	☐ Yes	☐ No	Physical	☐ Yes	☐ No

   If yes, please explain: _____

   _____

3. In your professional opinion, do you have concerns about this patient seeing well enough to safely operate a motor vehicle at night? ☐ Unable to answer ☐ Yes ☐ No

   If yes, please explain: _____

   _____

4. Do you suggest that the Department of State request a periodic vision evaluation? ☐ Yes ☐ No

   If yes, how often? Every ☐ 6 months ☐ 1 year ☐ 2 years ☐ 4 years

5. Do you recommend that the Department of State conduct a road test on this patient? ☐ Yes ☐ No

6. Additional Comments: _____

   _____

   _____

SECTION 7: VISION SPECIALIST CERTIFICATION

(Please complete entire certification)

As of this date, I certify that I have reviewed Sections 1 and 2 and completed Sections 3, 4, 5, and 6 and that this Vision Specialist's Statement of Examination is true and accurate to the best of my knowledge and belief. I understand the decision to grant, suspend, or reinstate an individual's driving privileges rests solely with the Department of State, which may consider other facts or conditions when making this decision.

Name_____ ☐ Optometrist ☐ Ophthalmologist

Address_____ City _____ State _____ Zip _____

Professional License Number _____ Telephone Number ( ) _____

Vision Specialist's Signature: _____ Date _____

FOR DRIVER ASSESSMENT USE ONLY

☐ FAVORABLE _____ ☐ COME-UP DATE _____
☐ RESTRICTION _____
☐ MUST PASS _____
☐ UNFAVORABLE _____
☐ QUESTIONABLE_____
☐ REFER FOR REEXAMINATION_____
☐ NEED ADDITIONAL INFORMATION _____
☐ MEDICAL ☐ VISION ☐ SKILLS TESTING ☐ SUBSTANCE USE DISORDERS EVALUATION

REVIEWED BY:_____ DATE:_____