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Form **999**

MISSOURI DEPARTMENT OF REVENUE

# Vision Examination Record

## Driver or Patient Information

| Last Name | First | Middle |
|---|---|---|
| | | |

| Date of Birth (MM/DD/YYYY) | Social Security Number |
|---|---|
| ____ ____ / ____ ____ / ____ ____ ____ ____ | \| \| \| \| \| \| \| \| \| |

| Mailing Address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

I hereby authorize and accept that:

- My physician will conduct an eye examination to determine if my visual abilities are adequate to operate a motor vehicle safely and responsibly.
- The Driver License Bureau will make a final decision concerning my eligibility for driver licensure based on all available information.

| Signature of Driver or Patient (Must be signed in the presence of physician) | Date (MM/DD/YYYY) |
|---|---|
| | ____ ____ / ____ ____ / ____ ____ ____ ____ |

## Physician Section

Are you a regular or primary eye care provider for this patient? ☐ Yes ☐ No

If yes, how many times have you seen this patient in the past year? _____

If no, are you evaluating this patient for the first time today? ☐ Yes ☐ No

| Distance Acuity | Left | Right | Both |
|---|---|---|---|
| W/O Correction | 20/ | 20/ | 20/ |
| With Correction | 20/ | 20/ | 20/ |
| Horizontal Field Width | | | |

Remarks: (special restrictions, severity, stability, etc.)

| | |
|---|---|
| 20/40 or better in either eye, or both, corrected | Corrective lenses (A) |
| 20/100 or worse in left eye only, no aid or corrected | Left outside mirror (Y) |
| 20/100 or worse in right eye only, no aid or corrected | Right outside mirror (T) |
| 20/41 to 20/59, no aid or corrected | Daylight driving only (C); Corrective Lenses (A), if corrected reading |
| 20/60 to 20/74, no aid or corrected | Daylight driving only, restricted 45 mph (CF); Corrective Lenses (A), if corrected reading |

| Office Mailing Address | City | State | ZIP Code |
|---|---|---|---|
| | | | |

| Specialty | License Number | Phone Number | Fax Number |
|---|---|---|---|
| | | ( _ _ _ ) _ _ _ - _ _ _ _ | ( _ _ _ ) _ _ _ - _ _ _ _ |

| Physician Name (Print) | Signature | Date (MM/DD/YYYY) |
|---|---|---|
| | | __ __ / __ __ / __ __ __ __ |



**Mail to:** Driver License Bureau
P.O. Box 200
Jefferson City, MO 65105-0200

**Phone:** (573) 526-2407
**Fax:** (573) 522-8174
**E-mail:** DOR.DLB_Support

Visit http://www.dor.mo.gov/drivers/ for additional information.