Louisiana Department of Public Safety and Corrections
Office of Motor Vehicles
PO Box 64886, Baton Rouge, LA 70896-4886

Vision Examination Form DPSMV2301 (R 05/2022)

The bearer of this vision examination form is being required to undergo an examination by an optometrist/ophthalmologist. Authority for the requirement is based on laws of the State of Louisiana relating to the issuance of drivers' licenses. The completed report of examination will be used by the Department of Public Safety and Corrections as a guide in making a final determination on the bearer's application, which is now pending.

Note to Applicant: This vision examination form must be completed by your optometrist/ophthalmologist and returned to this office within 30 days from the "Date Issued" indicated below. Failure to comply will result in the suspension of your driving privileges.

☐ **Applicant failed to comply within thirty (30) days.**

To be Completed by the Office of Motor Vehicles

Applicant's Name _____ DOB _____ R/S_____ D/L#_____
Address _____ City _____
Date Issued _____ MVCA'S Initials _____ Badge # _____ Office # _____

Remarks (indicate the reason the form is being issued):_____
_____

Without Corrective Lenses	With Corrective Lenses
Right Eye 20/ ___	Right Eye 20/ ___
Left Eye 20/ ___	Left Eye 20/ ___
Both Eyes 20/ ___	Both Eyes 20/ ___

Tested on Wall Chart: ☐ **Yes** ☐ **No**

To be Completed by Optometrist or Ophthalmologist (Required)

Without Corrective Lenses	With Corrective Lenses	With New Rx
Right Eye 20/ ___	Right Eye 20/ ___	Right Eye 20/ ___
Left Eye 20/ ___	Left Eye 20/ ___	Left Eye 20/ ___
Both Eyes 20/ ___	Both Eyes 20/ ___	Both Eyes 20/ ___

Peripheral Vision Fields: Left_____ Right_____
Angle of Vision: Temporal Nasal Temporal Nasal

1. Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors? ☐ **Yes** ☐ **No**
2. In your opinion, should the patient wear corrective lenses to operate a motor vehicle? ☐ **Yes** ☐ **No**
3. Is there evidence of eye disease or injury that would affect the driving ability? ☐ **Yes** ☐ **No** If so, describe:_____
   _____
4. In your opinion, should the patient be restricted to "Daylight driving only"? ☐ **Yes** ☐ **No**
5. Do you recommend that an operator's license be denied on visual grounds? ☐ **Yes** ☐ **No** If so, what grounds? _____
   _____

To be Signed by the Patient (Required)

I hereby authorize the examining optometrist/ophthalmologist whose signature appears below to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

Date: _____ Signature of Patient: _____

To be Completed by the Optometrist or Ophthalmologist (Required)

In your opinion, from a vision standpoint, is it safe for this patient to operate a motor vehicle?

☐ **Yes** ☐ **No**

On the basis of your examination and/or knowledge of this patient, do you recommend periodic vision reports be submitted?

☐ **Yes** ☐ **No** If yes, how often? ☐ 6 months ☐ 1 year ☐ 2 years ☐ Other:_____

Remarks: _____

_____

Optometrist/Ophthalmologist Signature: _____ Date: _____

Optometrist/Ophthalmologist Printed Name: _____ Telephone #: _____

Optometrist/Ophthalmologist Address: _____