CERTIFICATE OF VISION FOR BIOPTIC DRIVERS

State Form 13226 (R/7-98)

The records in this series are confidential according to IC 9-24-10 and IC 9-14-3-1.

DRIVER OR APPLICANT INFORMATION

Name	Date of Birth (*month, day, year*)	Telephone number
Address (*number and street, city, state, ZIP code*)		
I authorize this information to be released to the Indiana Bureau of Motor Vehicles:	Signature of Applicant:	Date signed (*month, day, year*)

Please check one of the following, and complete all appropriate blanks:

☐ **First time applicant for Indiana bioptic driver's license**

Has applicant ever been licensed to drive? _____ Yes _____ No

If yes, 1) in which state was applicant licensed? _____

2) was previous license obtained with a bioptic? _____ Yes _____ No

☐ **Review of Indiana bioptic driver's license** ☐ **Renewal of Indiana bioptic driver's license**

RESULTS OF EYE EXAMINATION

Unaided visual acuity	Acuity with best Rx (Min. 20/200)	Acuity with telescope (Min. 20/40)
OD _____ OS _____	OD _____ OS _____	OD _____ OS _____
Carrier lens prescription	Power and model of telescope	
OD _____ OS _____	OD _____ OS _____ Model _____	
Horizontal visual field diameter (Minimum 120)	Instrument used (*enclose diagram for first time applicants*)	
OD _____ OS _____ OU _____		

Describe any tinting prescribed

Color perception adequate to recognize traffic signal colors (*red, green, amber*): _____ Yes _____ No

Diagnosis of eye condition

Approximate date of onset (*day,month, year*)	Stability of vision (*for first time applicants*) Vision stable for at least 3 months? _____ Yes _____ No	
Examination date (*day, month, year*)	Dispensing date (*day, month, year*)	Further vision loss is: ☐ Unlikely ☐ Possible ☐ Likely

RECOMMENDED RESTRICTIONS

☐ Daylight driving only ☐ Limited driving radius ☐ Segmented rear view mirror

☐ Other _____

Appropriate candidate for night driving evaluation during driving training? _____ Yes _____ No

(*If yes, please give results of testing in reduced illumination or other medical rationale for this recommendation in comments section below:*)

In my opinion, a vision report should be submitted to the BMV: ☐ Annually ☐ Biennially

☐ Other (*specify interval*) _____

Other comments and observations

LOW VISION SPECIALIST CERTIFICATION (*PRINT OR TYPE*)

Name	Degree	Telephone number
Address (*number and street, city, state, ZIP code*)		
Signature	License number	Date (*day, month, year*)