



OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

**VISION EXAMINATION FOR OUT-OF-STATE
DRIVER LICENSE APPLICANTS**

In accordance with Ohio Revised Code (R.C.) 4507.12, all applicants renewing their Ohio driver license are required to submit to a vision screening procedure. No license shall be issued to any person until the person's vision is corrected to meet the vision screening required by this section.

APPLICANT - This form must be returned with your application for renewal of your Ohio driver license. Also, results must be submitted in the English language or it will be returned.

OHIO DRIVER LICENSE #		SOCIAL SECURITY #			DATE
APPLICANT LAST NAME		APPLICANT FIRST NAME			MI
OHIO RESIDENCE ADDRESS		CITY			ZIP CODE
DATE OF BIRTH	SEX	HEIGHT	WEIGHT	HAIR	EYES

I, _____, hereby authorize a licensed optometrist or ophthalmologist, to examine me and provide the following information regarding my visual condition to the Ohio Bureau of Motor Vehicles.

OPHTHALMOLOGIST/OPTOMETRIST - Please conduct these examinations and return this form to the applicant. **ALL SECTIONS (INCLUDING HORIZONTAL FIELDS) MUST BE COMPLETED. ALL RESULTS MUST BE SUBMITTED IN THE ENGLISH LANGUAGE OR IT WILL BE RETURNED.**

ACUITY			HORIZONTAL FIELD (DEGREES ONLY)			
	Right	Left	Both		Right	Left
Without Lenses	20/	20/	20/	Nas Temp	o	o
With Present Lenses	20/	20/	20/		o	o
With New Lenses	20/	20/	20/			

The Horizontal Field refers to the **angular extent of absolute limit of vision** (in degrees) nasal and temporal from fixation for each eye as measured with a large perimetry target.

Does the applicant pass the color vision test? (Farnworth D-15) YES NO

Except for normal deterioration due to aging, does the applicant have a progressive visual deficiency? YES NO

If "YES", please describe condition. _____

Due to this condition, is it necessary for the Ohio Bureau of Motor Vehicles to receive periodic vision exams? YES NO

CERTIFICATION - The information that I have provided is based upon my examination of the person named hereon and to the best of my knowledge is true and correct.

NAME OF OPTHALMOLOGIST/OPTOMETRIST		LICENSE #/REGISTRATION #		
ADDRESS	CITY	STATE/PROVINCE	ZIP CODE	
COUNTY	TELEPHONE #			
SIGNATURE OF OPTHALMOLOGIST/OPTOMETRIST X			EXAMINATION DATE	

I, _____ certify that I have had my vision abnormalities, if any, corrected by a licensed Ophthalmologist/Optometrist.

X _____
APPLICANT SIGNATURE DATE

BUREAU USE ONLY

RESTRICTED TO: A <input type="checkbox"/> NONE B <input type="checkbox"/> CORRECTIVE LENSES G <input type="checkbox"/> DAYLIGHT DRIVING ONLY	F1 <input type="checkbox"/> L OUTSIDE & INSIDE MIRRORS F2 <input type="checkbox"/> RT OUTSIDE & INSIDE MIRRORS
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