PLEASE RETURN COMPLETED VISION FORM TO:

PH: (785) 368-8971
FAX: (785) 296-5857

STATE OF KANSAS DIRECTOR OF VEHICLES
MEDICAL/VISION UNIT
300 SW 29th ST.
PO BOX 2188
TOPEKA KS 66601-2188

KANSAS DIVISION OF VEHICLES VISION FORM

GENERAL INFORMATION & HISTORY – TO BE FILLED OUT BY THE PATIENT

Name:____ Driver's License #: ________________ DOB: ___________

Address: ____ CITY/STATE/ZIP:

Phone Number:____

Currently enrolled in Driver's Education? YES / NO If yes, instructor name & phone number: ________________________________

RELEASE OF INFORMATION

Permission is granted for release of all vision information concerning me to the Kansas Division of Vehicles by all medical professionals filling out this form.

____ ______________________________

SIGNATURE OF PATIENT DATE

To the Vision Professionals: You assume no responsibility in making this report other than that of truthfully representing the facts as they appear in your professional judgment. **The information on this form must be from an examination within the last 90 days. If you have any questions please call (785)368-8971.**

Instructions:

1. Please answer each question and fill out the entire form carefully and legibly.
2. Indicate yes or no whether from a visual standpoint only, this patient is capable of safely operating a motor vehicle.
3. Specify any driving restrictions that are appropriate based on the patient's vision condition.

SECTION I: VISION REPORT

	Acuity Right Eye	Acuity Left Eye	Horizontal Field of Vision
Visual Acuity without Glasses	20/______	20______	
Visual Acuity with Glasses	20/______	20______	Equal to or greater than 20°?
Best Correction	20/______	20______	Yes ☐ No ☐
Bioptic/Telescopic (for vision specialist use only)	20/______	20______	

Driver requires a Permit to test adaptive equipment.	☐ Yes	☐ No
Does this patient require a drive test?	☐ Yes	☐ No
This patient is capable of safely operating a motor vehicle. (Driver must be considered a safe candidate in order to request a drive test.)	☐ Yes	☐ No
An annual vision report should be required.	☐ Yes	☐ No
Does this patient require a medical exam?	☐ Yes	☐ No

Indicate below which restrictions may apply to the patient's license if issued or continued: Maximum 6 restrictions. To remove a restriction(s) previously requested by a physician, please check the restriction box and write "R" beside it.

☐ Corrective Lenses	☐ Daylight Hours Only	☐ No Interstate Driving	☐ Outside Business Area
☐ Within City Limits	☐ Licensed Driver in Front Seat	☐ Automatic Transmission	☐ Outside Mirror
☐ Mechanical Aid	☐ Prosthetic Aid	☐ ________Miles From Home (5-30 in 5 mile increments)	

______________________________________ ______________________________________
Name of Optometrist/Ophthalmologist (Please print) Date of Examination

______________________________________ ______________________________________
Address Signature of Optometrist/Ophthalmologist

______________________________________ ______________________________________
Phone Date Signed

DV-124V (Rev 1218)