

CERTIFICATE OF VISION EXAMINATION BY COMPETENT AUTHORITY

MV3030V 5/2008 Ch. 343 Wis. Stats. and Trans. 112 Admin. Code

APPLICANT: You may be required to file vision reports on a regular basis.
We will send you the forms at the time they are required.

Wisconsin Department of Transportation
Medical Review
PO Box 7918
Madison WI 53707-7918
Telephone: 608-266-2327
FAX: 608-267-0518
E-Mail: dre.dmv@dot.state.wi.us

Incomplete forms will be returned for completion.

Name		Operator License Number	
Street Address		Birth Date	
City, State ZIP Code		Area Code - Telephone Number	
Date Issued	Examiner Badge Number	License Type <input type="checkbox"/> Instruction <input type="checkbox"/> Permit	<input type="checkbox"/> CDLI <input type="checkbox"/> CDL <input type="checkbox"/> Operator <input type="checkbox"/> Passenger Bus <input type="checkbox"/> School Bus

Minimum standards for non-commercial drivers - 20/100 vision or better in at least **(1) one** eye and 20° field of vision from center of at least **(1) one** eye. **Minimum Wisconsin standards for commercial drivers** (*applies to drivers grandfathered or exempted by federal or state law*) - 20/60 vision or better in at least **(1) one** eye and 70° field of vision from center of at least **(1) one** eye. **Minimum federal and school and/or passenger endorsement standards** - 20/40 vision or better in **each** eye, 70° field of vision from center in **each** eye and ability to distinguish traffic signal colors. **Bioptic lenses may not be used to meet standards.** All standards refer to the best vision with or without corrective lenses.

Report must be completed based on an examination conducted within the past 90 days or since _____.

VISION SPECIALIST: The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver licensing. Your report will be advisory in determining eligibility.

Indicate Snellen Chart Figures

Visual Acuity	Without RX	With RX	Temporal Field of Vision In Degrees
Right Eye	20/	20/	
Left Eye	20/	20/	

Yes No

- 1. Does applicant have progressive eye condition(s)? If yes, what? _____
- 2. Is applicant able to distinguish traffic signal colors or red, amber and green?
- 3. Is applicant safe to operate a non-commercial motor vehicle?
- 4. Is applicant safe to operate a commercial motor vehicle?
- 5. Is applicant safe to operate a passenger and/or school bus?
- 6. Re-examination by DOT (knowledge, highway signs & road test)
- 7. Recommended restrictions: _____ Corrective lenses _____ Daylight Driving Only
 _____ Miles from home _____ Other:

Comments: _____

Specialist - Print Name	Check One: <input type="checkbox"/> MD <input type="checkbox"/> OD <input type="checkbox"/> APNP	Medical License Number
Office Address		Area Code - Office Telephone Number
Specialist - Signature		Patient Examination Date: Month - Day - Year

X

Pursuant to s.448.01(5) and s.449.01(1) Wis. Statutes and Trans Ch. 112.02(16) Wis. Admin. Code, this form must be signed by an MD, OD or APNP.