NEBRASKA DEPARTMENT OF MOTOR VEHICLES

STATEMENT OF VISION

Once completed, please mail or fax to: P.O. Box 94726 Lincoln, NE 68509

FAX: 402-471-4020 Email: dmv.vismed@nebraska.gov **NOT VALID AFTER 90 DAYSFROM EXAMINATION DATE**

(Applicant completes before doctor's exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my visual condition and history to the Department of Motor Vehicles, State of Nebraska.

Dated: ____________________ Signed: ____________________
(Applicant's Signature)

I hereby certify that I examined the eyes of ____________________
(Applicant's Name)

of ____________________
(Street Address) *(City)* *(Zip Code)*

Date of Birth ____________________ License Number ____________________

To be completed by optometrist or ophthalmologist. (REQUIRED)

1. Unaided acuity: Both __________ Left Eye __________ Right Eye__________

2. a. Best correctable acuity: Both __________ Left Eye __________Right Eye __________

   b. Visual acuity using telescopic lens: 20/______ (Both) 20/______ (Left) 20/______ (Right)

   c. Visual acuity through carrier lens: 20/______ (Both) 20/______ (Left) 20/______ (Right)

   d. Type of lenses used: Std. Spectacle __________ Aphakic __________
   Contact Lenses __________ Telescopic Lenses __________

3. Extent of entire horizontal form field, either binocular or monocular, as determined with a III4e or V4e Goldmann test target or equivalent, such as the SSA Kinetic V4e isopter test on Humphrey Field Analyzers.

   Left Eye: ________ Degrees Temporal Right Eye: ________ Degrees Temporal
   ________ Degrees Nasal ________ Degrees Nasal

   Field of Vision looking through carrier lens: ________° Temp (Left) ________° Temp (Right)
   ________° Nasal (Left) ________° Nasal (Right)

DMV 06-18/TSIE6
07/12

To be completed by optometrist or ophthalmologist. (REQUIRED)

4. Are new corrective lenses required? Yes _____ No _____

5. Diplopia: *(Check appropriate line.)*

   ______ a. highly unlikely to occur

   ______ b. intermittent* *Please Explain:________________________________

   ______ c. constant* ____

6. If best visual acuity is less than 20/40 in either eye or both, or total horizontal form field is less than 140 degrees, give cause and probable prognosis under Additional Comments.

Answer questions #7 and #8 only for commercial motor vehicle operators.

7. Based upon your examination, has the vision condition of this patient, which was in existence prior to July 30, 1996, significantly worsened or another condition developed? ☐ No ☐ Yes

   If yes, please explain: ____

   ____

8. Color blindness: Able to recognize the colors of traffic signals and devices showing standard red, green and amber. ☐ No ☐ Yes

9. In my opinion, this applicant should have their vision retested for driving purposes in ____ years.

10. **Date of eye examination:** ______________________________

    (MUST BE COMPLETED—STATEMENT OF VISION NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE.)

Additional Comments: ____

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______________________________ ______________________________

Name of Optometrist or Ophthalmologist (Please Print) Signature of Optometrist or Ophthalmologist*

____

Address of Optometrist or Ophthalmologist (Please Print)

Telephone Number of Optometrist or Ophthalmologist: (____) ______________________

Fax Number of Optometrist or Ophthalmologist: (____) ______________________

* **If the applicant needs new corrective lenses to get the best correctable acuities listed on page 1, please delay signing this statement until the new lenses are in use by the applicant.**