**EXPLANATION FOR EYE SPECIALIST**

The Motor Vehicle Division requires information to verify a driver meets Montana vision standards for the purpose of driver license issuance. This form must be completed by an eye specialist. The eye specialist assumes no responsibility in making this report other than that of precisely representing the facts.

Please complete this form for the examination you conduct. Attach a separate sheet if the case is unique and additional comments are necessary. For proper identification, have the driver sign the report in your presence.

**RELEASE OF INFORMATION BY DRIVER – SIGN IN PRESENCE OF EYE SPECIALIST**

I authorize my eye specialist to answer any questions from the Motor Vehicles Division or its employees relating to my physical or medical condition and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana.

I authorize the Motor Vehicle Division to receive any information relating to my physical or medical condition and to use the same in determining whether I have the ability to safely operate a motor vehicle.

Signed: ___________________________ Date: ____________

<table>
<thead>
<tr>
<th>Vision Test:</th>
<th>Without Correction:*</th>
<th>With Correction:*</th>
<th>With New RX</th>
<th>BREADTH OF VISION FIELD (*Required for CDL Drivers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Eyes</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
<td>To Right of Point of Fixation</td>
</tr>
<tr>
<td>Left Eye</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
<td>To Left Point of Fixation</td>
</tr>
<tr>
<td>Right Eye</td>
<td>20/</td>
<td>20/</td>
<td>20/</td>
<td>Total Angle</td>
</tr>
</tbody>
</table>

Type of Instrument used to determine visual acuity: ☐ System ☐ Snellen Chart

Are you fitting corrective lenses for distance? ☐ Yes ☐ No

Is there double vision? ☐ Yes ☐ No

If yes, describe: ____________________________________________________________

Can the double vision be corrected with corrective lenses? ☐ Yes ☐ No ☐ N/A

If yes, describe: ____________________________________________________________

Is there evidence of eye disease or injury resulting in vision impairment? ☐ Yes ☐ No

If yes, describe: ____________________________________________________________

Are there any known problems with night vision? ☐ Yes ☐ No

If yes, describe: ____________________________________________________________

Does the patient have red, green, or amber color deficiencies? ☐ Yes ☐ No

If yes, explain: ____________________________________________________________

Does the patient have a vision condition that requires monitoring by MVD? ☐ Yes ☐ No

If yes, how often do you recommend monitoring? ☐ 6 months ☐ 1 year ☐ 2 years ☐ _______ Years

**CERTIFICATION OF EYE SPECIALIST**

Print Name* ___________________________ Type of Practice of Medical Specialty* ___________________________ Medical License Number* ___________________________

Address ___________________________ Email ___________________________ Phone Number* ___________________________

Signature* ___________________________ Date* ___________________________