



# Eye Examination for Driver License Mail Renewal

Form 3 of 3

ATTN RNRP P.O. Box 201430 Helena, MT 59620-1430 • Phone (406) 444-1352 • Fax (406) 444-2086 • www.doj.mt.gov

Legal Last Name	Legal First Name	Legal Middle Name	Suffix (Jr, Sr, 1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> )
Date of Birth	Montana Driver License Number	Phone Number or Email Address	

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

I authorize my eye specialist to answer any questions from the Motor Vehicle 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. I affirm under penalty of law (MCA 61-5-303) that the information on this application is true and correct to the best of my knowledge, information and belief.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INTRODUCTION TO EYE SPECIALIST:**

The Motor Vehicle Division asks a driver license applicant to visit an eye specialist when the applicant is unable to appear in person for a renewal, unusual eye defects are apparent during tests conducted at an exam station, more accurate measurements are needed, or an improvement in vision would make driving safer. In some cases, examinations by more than one specialist are requested. Driver license examiners do not recommend or suggest health care providers to applicants.

Please complete this form for the examination you conduct. Leave blank any items not covered during the examination. Attach a separate sheet if the case is unique and additional comments are necessary. Only a report from an eye specialist is acceptable. The eye specialist assumes no responsibility in making this report other than that of precisely representing the facts. For proper identification, have the driver sign the report in your presence.

**RECORD FOR EXAMINATION**

Distant Vision Only	Right Eye Only	Left Eye Only	Both Eyes Together	BREADTH OF VISION FIELD	
With Present Glasses	20/ /	20/ /	20/ /	To Right of Point of Fixation	To Left of Point of Fixation
Without Glasses	20/ /	20/ /	20/ /	_____	_____
Best Possible Correction	20/ /	20/ /	20/ /	Total Angle _____	

Type of instrument used to determine visual acuity: \_\_\_\_\_ Are you fitting glasses/ contacts for distant vision? No Yes  
 Is there double vision? No Yes describe: \_\_\_\_\_  
 Can condition be corrected with glasses? No Yes Other treatment? No Yes Explain: \_\_\_\_\_  
 Are you undertaking such correction or treatment? No Yes Explain: \_\_\_\_\_  
 Is there any evidence of eye disease or injury? No Yes Explain: \_\_\_\_\_  
 Is there any unusual difficulty seeing in dim light or at night? No Yes Explain: \_\_\_\_\_

**CERTIFICATION OF EYE SPECIALIST**

Signature:	Name (printed):	Date:
Type of Practice or Medical Specialty:	Address (include city, state, zip):	Telephone Number:
Medical License Number:		