Motor Vehicle Administration
6601 Ritchie Highway, N.E.
Glen Burnie, Maryland 21062

DL-043A (12-13)

Vision Screening Form

This form may be used to record:
- MVA's vision screening results, if the screening has taken place
- Your vision specialist's examination results

Driver/Patient's full name: _____

Driver/Patient's Maryland driver's license number: _____

MVA Vision Screening Results: Findings from MVA's Vision Screening (*For MVA use only*)

	Right Eye	Left Eye	Both Eyes	Field of Vision Continuous?	Color vision problems?	MVA employee:
Acuity without lenses	20/	20/	20/			
Acuity with present lenses	20/	20/	20/	❒ yes	❒ yes	MVA office:
Field of Vision (degrees)	degrees	degrees	degrees	❒ no	❒ no	Date:

Vision Specialist's Examination Results and Certification

Vision Exam Date: _____ Diagnosis, if applicable: _____

	Right Eye	Left Eye	Both Eyes	Binocular Vision?	Please Note: The Snellen test must be used
Acuity without lenses	20/	20/	20/		
Acuity with present lenses	20/	20/	20/	❒ yes	Please do not enter acuities achieved by telescopic lenses in this chart.
Acuity with best standard spectacle correction	20/	20/	20/	❒ no	
Field of Vision (in degrees)	degrees	degrees	degrees		

- Are corrective lenses (standard spectacle) needed to meet vision requirements for driving? ❒ yes ❒ no
  If corrected lenses are needed, has this patient acquired the lenses? ❒ yes ❒ no
- Will treatment improve this patient's vision for driving? ❒ yes ❒ no
  If yes, please describe: _____
- Does this patient meet the continuous field of vision requirements specified by the MVA? ❒ yes ❒ no
- Did the visual examination reveal any optical or medical reason that could preclude granting a license? ❒ yes ❒ no
  (If yes, please submit a complete report for the MVA's Medical Advisory Board.)
- For commercial licenses only: Can this patient distinguish between red, green and amber colors? ❒ yes ❒ no

Even if this individual is presently eligible to renew by mail, I understand I may contact the Medical Advisory Board for follow-up if I later detect any change in visual acuity that may affect fitness to drive.

I certify under penalty of perjury that the information contained hereon is true and accurate to the best of my knowledge, information and belief.

Ophthalmologist/Optometrist's Signature Printed Name Date

Licensed to practice: ❒ Medicine ❒ Ophthalmology ❒ Optometry in the state of : _____

Ophthalmologist/Optometrist's Address Phone Number