MARYLAND DEPARTMENT OF TRANSPORTATION MOTOR VEHICLE ADMINISTRATION	**Vision Specialist / Modified Vision Program (DC-040E)** **Driver Wellness & Safety**	Questions? Please call 410-768-7513 TTY for the deaf 1-800-735-2258 Visit our website at: www.MVA.Maryland.gov

DRIVER LICENSE IDENTIFICATION NUMBER	DATE OF BIRTH	TODAY'S DATE

LAST NAME	FIRST	MIDDLE

INSTRUCTIONS TO DRIVER: Complete Section A and have your Ophthalmologist/Optometrist complete Section B. The medical provider should return this form to the MVA.

(Please note: Payment for any examination and preparation of this form is your responsibility.)

SECTION A - TO BE COMPLETED BY DRIVER (Print or Type)			
Driver's License Number			Today's Date
Last Name	First	Middle	Date of Birth
Address			

SECTION B – TO BE COMPLETED BY OPHTHALMOLOGIST/OPTOMETRIST

INSTRUCTIONS TO MEDICAL PROVIDER: Participation in this MVA Modified Vision Program is determined by an individual's vision with the best standard spectacle or contact lens correction, in the applicant's better eye. The use of bioptic telescopic lenses are not considered in determining an individual's qualification to participate in this program. To qualify for the Modified Vision Program driver's must have: Visual acuity less than 20/70, but no worse than 20/100 and Continuous field of vision of at least 110 degrees with at least 35 degrees lateral to the midline of each side. (Note: Drivers with limited field of vision may use this form to apply under the Modified Visual Field Program.)

Maryland Motor Vehicle Law requires that an applicant seeking a license under this program be recommended for license consideration by the applicant's licensed Ophthalmologist or Optometrist. The Ophthalmologist or Optometrist recommendation MUST be based on the best standards spectacle or contact lens correction in the applicant's better eye.

Please complete the remainder of this report and return to:

For quickest processing, including 24/7 access to case information and updates, **upload all of your required documents securely with a myMVA account.** To create an account visit: https://mymva.maryland.gov/go/web/CreateMyMVAProfile. You may also choose to send all requested items

by mail to MVA, Driver Wellness and Safety Division, Room 124, 6601 Ritchie Highway, NE, Glen Burnie, MD 21062.

1. Date of Examination: _____

2. Briefly describe cause and nature of the applicant's vision condition: _____

_____

3. Is visual deficit the result of an underlying condition? (i.e. Diabetes, TBI, CVA) ☐ Yes* ☐ No

If yes, please specify _____

4. Is this vison condition stable? ☐ Yes ☐ No

***Please inform the driver that it is their responsibility to have their primary care provider complete a "Physician's Report Form" for review by MVA's Medical Advisory Board.**

MVA Modified Vision Program qualifications:
•Visual acuity less than 20/70, but no worse than 20/100
•Continuous field of vision of at least 110 degrees with at least 35 degrees lateral to the midline of each side
(See page 1, Instructions to Medical Provider, for more information regarding this program)

5. Visual Acuity and Field of Vision

	Right Eye	Left Eye	Both Eyes
Acuity without corrective lenses	20/_____	20/_____	20/_____
Acuity with corrective lenses	20/_____	20/_____	20/_____
Field of Vision	_____ degrees	_____ degrees	_____ degrees

6. Does the driver's vertical field of vision contraindicate safe driving? ☐ Yes ☐ No

7. Did your vision examination include any other vision tests? ☐ Yes ☐ No

_____

If yes, please specify: _____

MEDICAL PROVIDER ATTESTATION

The Information contained herein Is true and complete to the best of my knowledge, information, and belief.

Vision Specialist's Printed Name _____

License State/Number _____

Address _____

Phone Number _____ Fax Number_____

Signature _____ Date _____