



WYOMING DEPARTMENT OF TRANSPORTATION  
 Driver Services  
 5300 Bishop Blvd  
 Cheyenne, wY 82009-3340  
 Phone: (307) 777-4810 Fax: (307) 777-4817

**DRIVER VISION EVALUATION**

NAME (Printed) _____	DRIVER LICENSE # _____	<input type="checkbox"/> Commercial Driver License
MAILING ADDRESS _____	DATE OF BIRTH _____	
CITY _____	STATE _____	ZIP CODE _____
MVID # (Staff Use Only) _____		

CDL driver must have a visual acuity of at least 20/40 or better in each eye with or without corrective lenses, and at least 70 degrees horizontal field of vision in each eye; for a combined total field of vision of 140 degrees.

	<u>WITHOUT LENSES</u>	<u>PRESENT LENSES</u>	<u>BEST CORRECTION</u>
RIGHT EYE	20/ _____	20/ _____	20/ _____
LEFT EYE	20/ _____	20/ _____	20/ _____
BOTH EYES	20/ _____	20/ _____	20/ _____

1. Date of last examination (must be within previous 3 months): \_\_\_\_\_
2. Is horizontal visual field at least a combined total field of 120 degrees with both eyes?  YES  NO  
 Does patient have depth perception?  YES  NO
3. Is patient wearing best possible correction?  YES  NO
4. Does patient require bioptic/telescopic lenses for driving?  YES  NO  
 If yes, please explain: \_\_\_\_\_
5. Visual Condition: \_\_\_\_\_
6. A Driver Vision Evaluation statement should be obtained each year to determine patient's eligibility for a driver's license.  YES  NO
7. Patient's visual condition is such that a driving skills test should be administered at this time to determine if he/she can safely operate a motor vehicle.  YES  NO
8. Recommended driving restrictions:
 

<input type="checkbox"/> NONE	<input type="checkbox"/> L&R Outside Rearview Mirrors	<input type="checkbox"/> Daylight driving only
<input type="checkbox"/> No interstate driving	<input type="checkbox"/> Driving only within the city limits	<input type="checkbox"/> Driving only with a ___ mile radius of home
<input type="checkbox"/> Other: _____		
_____		
_____		
_____		

_____ Optometrist/Ophthalmologist Name (printed)	_____ Address	_____ Telephone No.
_____ Optometrist/Ophthalmologist Signature	_____ Date	