STATE OF MISSISSIPPI
DEPARTMENT OF PUBLIC SAFETY

REQUEST FOR STATEMENT OF VISION SPECIALIST

Form must be type-written or printed

Driver License Number: ______________________________

I, ______________________________ hereby authorize and request that information regarding my visual condition be released to the Driver Services Bureau, Department of Public Safety.

Date: ____________ Signature: ______________________________

Address: ______________________________ City: ____________ State: ______ Zip: ________

*** INFORMATION BELOW TO BE COMPLETED BY OPHTHALMOLOGIST OR OPTOMETRIST***

Patient's Name: ______________________________ Date of Birth: ____________

How long has this patient been under your care? ____________ Date of Visual Exam: ________

	WITHOUT LENSES	WITH PRESENT LENSES	WITH NEW LENSES	FIELD OF VISION
Right Eye	20/	20/	20/	To Right of Point of Fixation
Left Eye	20/	20/	20/	To Left of Point Fixation
Both Eyes	20/	20/	20/	Total Angle

Prognosis: ______________________________

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On the basis of my findings, it is my opinion that (ONE OF THE FOLLOWING SELECTIONS MUST BE CHECKED):

___ Present vision is adequate for safe driving.
___ The applicant should drive only while wearing adequate corrective lenses.
___ Driving should be limited to daylight driving only.
___ The applicant should not be licensed to drive. (Please provide any supporting documentation or comments that you may have.)

Comments: ______________________________

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Name: ______________________________

Address: ______________________________ City ____________ State: ________ Zip: ________

Signature: ______________________________ Date: ____________

PLEASE INDICATE: __ OPHTHALMOLOGIST __ OPTOMETRIST

This form is valid for one year from date of issuance