

STATE OF MISSISSIPPI  
DEPARTMENT OF PUBLIC SAFETY  
DRIVER SERVICES  
P. O. BOX 958  
JACKSON, MISSISSIPPI 39205

DRIVER'S LICENSE NO. \_\_\_\_\_  
SOCIAL SECURITY NO. \_\_\_\_\_

## REQUEST FOR STATEMENT OF VISION SPECIALIST

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 \_\_\_\_\_  
No. & Street 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 of Fixation ○
Both Eyes	20/	20/	20/	Total Angel ○
Other Conditions	_____			

Prognosis \_\_\_\_\_

On the basis of my findings, it is my opinion that:

- ( ) 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.

COMMENTS \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SIGNATURE \_\_\_\_\_

(PLEASE INDICATE)  OPHTHALMOLOGIST  
 OPTOMETRIST