Montana Department of Justice
MVD
Motor Vehicle Division
Safety • Efficiency • Dependability

Report of Eye Examination
Form 3

Print Form

302 North Roberts Street
P.O. Box 201430
Helena, MT 59620-1430
Out-of-State: (406) 444-4590
Out-of-State FAX (406) 444-7623
In-State (406) 444-3273
In-State FAX (406) 444-1631

Please Return Completed Form to Driver

Driver's Legal Name		Driver License No.	Birth Date (mm/dd/yyyy)
Driver's Mailing Address	City	State Zip	Daytime Phone No. ( )

Explanation for Eye Specialist

The Motor Vehicle Division asks a driver license applicant to visit an eye specialist when the applicant is unable to appear in person for a renewal, unusual eye defects are apparent during tests conducted at an exam station, more accurate measurements are needed, or an improvement in vision would make driving safer. In some cases, examinations by more than one specialist are requested. Driver license examiners do not recommend or suggest health care providers to applicants.

Please complete this form for the examination you conduct. Leave blank any items not covered during the examination. Attach a separate sheet if the case is unique and additional comments are necessary. Only a report from an eye specialist is acceptable. The eye specialist assumes no responsibility in making this report other than that of precisely representing the facts. For proper identification, have the driver sign the report in your presence.

RELEASE OF INFORMATION BY DRIVER – SIGN IN PRESENCE OF EYE SPECIALIST

I authorize my eye specialist to answer any questions from the Motor Vehicle Division or its employees relating to my physical or medical condition and to release any related information or records to the Motor Vehicle Division or its employees. Any expense involved is to be charged to me and not the State of Montana.

I authorize the Motor Vehicle Division to receive any information relating to my physical or medical condition and to use the same in determining whether I have the ability to safely operate a motor vehicle.

Signed: X _____ **Date:** _____

Record of Examination

Distant Vision Only	Right Eye Only	Left Eye Only	Both Eyes Together
With Present Glasses	20/ /	20/ /	20/ /
Without Glasses	20/ /	20/ /	20/ /
Best Possible Correction	20/ /	20/ /	20/ /

BREADTH OF VISION FIELD

To Right of Point of Fixation _____

To Left of Point of Fixation _____

Total Angle _____

Type of instrument used to determine visual acuity: _____ Are you fitting glasses for distant vision? ☐ No ☐ Yes

Is there double vision? ☐ No ☐ Yes If **yes**, describe: _____

Can condition be corrected with: Glasses? ☐ No ☐ Yes Other treatment? ☐ No ☐ Yes If **yes**, describe: _____

Are you undertaking such correction or treatment? ☐ No ☐ Yes _____

Is there any evidence of eye disease or injury? ☐ No ☐ Yes If **yes**, describe: _____

Is there any unusual difficulty seeing in dim light or at night? ☐ No ☐ Yes If **yes**, explain: _____

Certification of Eye Specialist

Signature:	Printed Name:	Date:
Type of Practice or Medical Specialty: Medical License Number:	Address:	Telephone Number: