OMB APPROVAL NO 1405-XXXX
EXPIRATION DATE: XX-XX-20XX
ESTIMATED BURDEN: XX MINUTES

U.S. Department of State
Bureau of Medical Services

DRIVER MEDICAL EVALUATION: VISION ASSESSMENT FORM

Instructions: This form can be used for individuals who cannot pass the vision acuity or peripheral vision testing (with or without correction), or who report other vision deficiencies or conditions. This form must be completed by an optometrist or ophthalmologist (or local equivalent).

Section I: Driver Information

Name *(Last, First, MI)*	Date of Birth (*mm-dd-yyyy*)

Section II: Vision History

DISTANT VISUAL ACUITY

ACUITY	UNCORRECTED	CORRECTED*	How was testing performed?
Right Eye	20/ _____	20/ _____	
Left Eye	20/ _____	20/ _____	
Both Eyes	20/ _____	20/ _____	

*If corrected, what was the patient wearing during the visual acuity exam? ☐ Contact Lenses ☐ Corrective Lenses

FIELD OF VISION

ACUITY	HORIZONTAL FIELD OF VISION	How was testing performed?
Right Eye	_____ °	
Left Eye	_____ °	

MONOCULAR VISION

Does the individual have monocular vision with intact vision in one eye (20/40 with or without correction)? ☐ Yes ☐ No	If "Yes", describe treatment, and when it began (mm-dd-yyyy).

PROGRESSIVE EYE DISEASE

Does the individual have a progressive eye or vision condition or disease (e.g., cataracts, glaucoma, retinopathy, etc.)? ☐ Yes ☐ No	**IF YES:**	Condition	Date of Diagnosis (*mm-dd-yyyy*)	Severity	Current Treatment	Stable Condition? ☐ Yes ☐ No

VISION EXAMS

Do you recommend annual or more frequent eye exams? ☐ Yes ☐ No	Comments

RESTRICTIONS

Are there any local restrictions related to vision deficiencies and professional driving? ☐ Yes ☐ No	If "Yes", provide details.

Name of Examinee	DOB

COMMENTS

Section III: Provider/Clinician Recommendation

_____ (initial): I attest that I am an optometrist/ophthalmologist (or equivalent) and have examined and/or tested the vision of the above listed candidate's vision.

Based on my assessment above, performed on _____ (mm-dd-yyyy):

- ☐ The individual can safely drive, without restrictions.
- ☐ The individual can safely drive with the following restrictions/limitations: _____
- ☐ The individual should not drive at this time.

Name of Provider/Clinician	Signature of Provider/Clinician	Medical Credential/Specialty ☐ Optometrist ☐ Ophthalmologist ☐ Other: _____
Clinic Address/Post	Phone Number	Email

***Note**: even if the documentation indicates the individual can drive, this document will be reviewed as part of the overall driver medical evaluation and in accordance with the US Department of State Bureau of Medical Services Driver Medical Evaluation Policy.

Privacy Act Statement

Releases or disclosures of confidential medical information are governed by the Privacy Act of 1974, as amended, 5 U.S.C. § 552a et seq., and the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 701 et seq.

Paperwork Reduction Act Statement

AUTHORITIES: The information is sought pursuant to 5 CFR 930.108, 339.301 and the Foreign Service Act of 1980, as amended (Title 22 U.S.C. 4084, 3901, and 3984).

PURPOSE: The information requested on this form will be used to determine medical eligibility for issuance of a driver medical certificate.

ROUTINE USES: Unless otherwise protected by law, the information solicited on this form may be made available to appropriate agencies, whether Federal, state, local, or foreign, for law enforcement and other authorized purposes. The information may also be disclosed pursuant to court order. The information may also be made available to local Health Units. More information on the Routine Uses for the system can be found in the System of Records Notice State-24, Medical Records

DISCLOSURE: Providing this information is voluntary; however, failure to provide this information may result in denial of a driver medical certification.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

To the individual and/or health care provider completing the medical history review /exam: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you NOT provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.