INSTRUCTIONS TO APPLICANT

- This form must be completed by the Optometrist or Ophthalmologist prescribing the bioptic telescopic lens.
- This form must be completed based on an examination performed within 60 days.
- Failure to complete and return the form to the Office of Motor Vehicles within 90 days may result in the suspension or denial of driving privileges.
- After this form is reviewed by the Office of Motor Vehicles, a final decision will be determined as to the eligibility of issuance of driver’s license.
- The applicant only qualifies for a class E license. Applicant is not eligible for a commercial driver license (CDL) or a motorcycle endorsement.
- The following statement must be read and signed: I hereby authorize the examining physician whose signature appears below to release all information and findings contained herein to the Louisiana Department of Public Safety and Corrections. The Louisiana Department of Public Safety and Corrections can release this information to such individuals or groups as may be considered necessary and appropriate to determine my ability to safely operate a motor vehicle.

INSTRUCTIONS

- The applicant must demonstrate a visual acuity of at least 20/200 in one or both eyes and a field of 110 degrees horizontal vision without or with corrective carrier lenses. If he has vision in only one eye, he must have a field of at least 40 degrees temporal and 30 degrees nasal horizontal vision.
- The applicant must demonstrate a visual acuity of at least 20/60 in one or both eyes with the bioptic telescopic lenses and without the use of field expanders.
- The Optometrist or Ophthalmologist must certify that no ocular diagnosis or prognosis currently exists or is likely to occur during the period of issuance of the license which would cause deterioration of visual acuity or visual field to levels below the minimum standards.
- This form must be completed in its entirety by an optometrist or ophthalmologist based on an examination performed within 60 days.
- Incomplete forms may be rejected and could result in the denial of applicants driving privileges.
- Clip on or hand-held telescopic lens are not acceptable.
PATIENT’S NAME _______________________________________________ DOB ________________

1. Does the patient meet or exceed the minimum acceptable horizontal, binocular field of vision requirements. □ Yes □ No
   NOTE: Field expanders are not allowed to achieve vision requirements.
2. Can applicant recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors. □ Yes □ No
3. What medical conditions caused the present loss of the patient’s visual acuity?

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

4. Does the patient have any progressive diseases of the eye?
   - Cataracts □ Yes □ No
   - Diabetic Retinopathy □ Yes □ No
   - Glaucoma □ Yes □ No
   - Macular Degeneration □ Yes □ No
   - Retinitis Pigmentosa □ Yes □ No
   - Other □ Yes □ No If so, please describe. __________________________

4. How long has this patient been under your care? ________

1. What is the date of the most recent visual examination? ______________
2. On what date did patient receive telescopic lens? ______________
3. Did patient complete the prescribed training exercises for the use of the bioptic telescopic lens? □ Yes □ No
4. In your opinion, should the patient be restricted to “Daylight Driving Only”? □ Yes □ No
5. Can you certify that that no ocular diagnosis or prognosis currently exists or is likely to occur during the period of issuance of the license which would cause deterioration of visual acuity or visual field to levels below the minimum standards. □ Yes □ No
6. Patient should be re-evaluated every: □ 6 months □ Yearly

7. If license issued, what restrictions would be recommended.
   - 5 mile radius of home □ 10 mile radius □ 15 mile radius □ 20 mile radius □ 25 mile radius
   - No interstate highway □ light traffic only

Other special restrictions please explain: __________________________

____________________________________________________________________________________________________________

12 In your opinion, would the patient’s condition interfere with the safe operation of a motor vehicle? □ Yes □ No
   If “yes”, please explain in the space provided or attach an explanation on your letterhead.

____________________________________________________________________________________________________________

In accordance with the provisions of R.S. 40:1356, a health care provider is exempt from any liability as a result of reporting to the Department of Public Safety and Corrections any visual ability, physical condition, impairment or disability which may impair a person’s ability to exercise ordinary and reasonable control in the operation of a motor vehicle. This form must be completed in its entirety by an optometrist or ophthalmologist.

Physician’s Signature ___________________________ Date __________________

Physician’s Printed Name ___________________________ Telephone # (____) _____________

Physician’s Address ___________________________

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