Reset Form

CERTIFICATE OF VISION (EYE REFERRAL)

State Form 22106 (R5 / 12-12)
INDIANA BUREAU OF MOTOR VEHICLES

BUREAU OF MOTOR VEHICLES
ATTN: Medical/Vision Review Clerk
100 North Senate Avenue
Room N481
Indianapolis, IN 46204

INSTRUCTIONS:
1. *Complete in blue or black ink.*
2. *Upon a customer failing the original vision screening, a branch associate must complete Section A.*
3. *The customer must take this form to an ophthalmologist or optometrist to complete Section B - Certificate of Examination by Eye Doctor.*
4. *When Section B has been completed by an ophthalmologist or optometrist, the customer must take the completed form to a license branch.*
5. *If the vision screening at the license branch cannot be successfully passed the second time, the completed form must be mailed to the address above or faxed to (317) 233-5153.*

SECTION A: FOR LICENSE BRANCH USE

The attached certificate is for customer _____, Driver License Number _____, for an evaluation of a potential vision condition. The BMV's basic vision screening indicates need for further examination. Optec 1000 BMV findings are as follows:

ACUITY			GLASSES/CONTACTS	VISUAL FIELDS – LEFT	VISUAL FIELDS - RIGHT
Both 20/_____	Right 20/_____	Left 20/_____	☐ Yes ☐ No	☐ 70°T ☐ 55°T ☐ N	☐ N ☐ 55°T ☐ 70°T

Examiner's Comments:

Date *(mm/dd/yyyy)*	Branch Number	By *(License Branch Associate):*

SECTION B: CERTIFICATE OF EXAMINATION BY EYE DOCTOR (OPHTHALMOLOGIST OR OPTOMETRIST)

I have examined the below named driver for visual conditions which might have direct bearing upon his or her qualifications for a driver's license.

Name of Doctor	State Licensed to Practice	Date *(mm/dd/yyyy)*

Name of Driver	Date of birth *(mm/dd/yyyy)*	Telephone Number
		( )

WITHOUT LENSES			WEARING BEST POSSIBLE PRESCRIPTION		
Right Eye 20/ _____	Left Eye 20/ _____	Both Eyes 20/ _____	Right Eye 20/ _____	Left Eye 20/ _____	Both Eyes 20/ _____

Horizontal Diameter of Visual Fields	Fields Attached?	NOTE: See vision requirement chart below.
Right _____ Left_____	☐ Yes ☐ No	

Diagnosis of visual condition(s):

Further vision loss is:
☐ Unlikely ☐ Possible ☐ Likely

Prescription needed to achieve best corrected visual acuity:

✓	VISION REQUIREMENT CHART *(Check one if applicable)*
☐	I One eye 20/40 or better, other eye 20/40 or better, unaided NO RESTRICTIONS
☐	II Best eye 20/40 or better, other eye 20/50 to Blind, unaided OUTSIDE R/V MIRROR (F restriction)
☐	III One eye 20/40 or better, other eye 20/40 or better, corrected with glasses or contact lenses * GLASSES REQUIRED (B restriction)
☐	IV Best eye 20/40 or better, other eye 20/50 through Blind, corrected with glasses or contact lenses * GLASSES REQUIRED*, OUTSIDE R/V MIRROR (B, F restrictions)
☐	V One eye 20/50, other eye 20/50, corrected with glasses or contact lenses * GLASSES REQUIRED (B restriction)
☐	VI Best eye 20/50, other eye 20/70 to Blind, corrected with glasses or contact lenses * GLASSES REQUIRED*, OUTSIDE R/V MIRROR, DAYLIGHT DRIVING ONLY (B, F, G restrictions)
☐	VII One eye 20/70, other eye 20/70 to Blind, corrected with glasses or contact lenses * GLASSES REQUIRED*, OUTSIDE R/V MIRROR, DAYLIGHT DRIVING ONLY **(PERSON MUST HAVE PROOF OF NORMAL PERIPHERAL VISUAL FIELDS)** (B, F,G restrictions)

* License valid only while wearing glasses or contact lenses WHEN applicant requires the aid of glasses or contact lenses to pass Driver's License Vision Examination. Doctor must certify in writing if glasses will not improve vision.

Signature of Doctor	Typed or Printed Name of Doctor

M.D., O.D. Address *(number and street, city, state, and ZIP code)*	Telephone Number ( )

By signing I authorize this information to be released to the Indiana Bureau of Motor Vehicles.

Signature of Driver	Printed Name of Driver	Date Signed *(mm/dd/yyyy)*