Eye Evaluation

P.O. Box 201430, Helena, MT 59620-1430 ● Phone (406) 444-3933 ● Fax (406) 444-1631 ● www.dojmt.gov ● DriverLicense@mt.gov

Please PRINT

Legal **Last** Name	Legal **First** Name	**Driver License** Number	
Mailing Address	City	State	Zip
Email Address	**Phone Number**	Date of Birth	

Explanation for Eye Specialist

The Motor Vehicle Division requires information to verify a driver meets Montana vision standards for the purpose of driver license issuance. This form must be completed by an eye specialist. The eye specialist assumes no responsibility in making this report other than that of precisely representing the facts.

Please complete this form for the examination you conduct. Attach a separate sheet if the case is unique and additional comments are necessary. 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: **Date:**

Distant Vision Only	Right Eye Only	Left Eye Only	Both Eyes Together
With Present Corrective Lenses	20/	20/	20/
Without Corrective Lenses	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: ☐ System ☐ Snellen Chart Are you fitting corrective lenses for distance vision? ☐ Yes ☐ No

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

Can the double vision be corrected with corrective lenses? ☐ Yes ☐ No ☐ N/A Other treatment? ☐ Yes ☐ No ☐ N/A

Are you undertaking such correction or treatment? ☐ Yes ☐ No ☐ N/A

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

Are there any known problems with night vision? ☐ Yes ☐ No If **yes**, explain: _____

Does the patient have red, green, or amber color deficiencies? ☐ Yes ☐ No If **yes**, explain: _____

Does the patient have a vision condition that requires monitoring? ☐ Yes ☐ No

If yes, how often do you recommend monitoring? ☐ 6 months ☐ 1 year ☐ 2 years ____ years

Certification of Eye Specialist

Print Name:	Type of Practice or Medical Specialty:	Medical License Number:
Address:	Email:	Phone Number:
Signature:		Date: