CERTIFICATE OF VISION EXAMINATION BY COMPETENT AUTHORITY

MV3030V/T579 7/2014 Ch. 343 Wis. Stats. and Trans. 112 Admin. Code

Wisconsin Department of Transportation
Medical Review
PO Box 7918, Madison, WI 53707-7918
Telephone: (608) 266-2327
FAX: (608) 267-0518
Email: dmvmedical@dot.wi.gov

APPLICANT: You may be required to file vision reports on a regular basis. We will send you the forms at the time they are required.

Clear Form

Incomplete forms will be returned for completion.

Applicant Name – First, Middle Initial	Driver License Number
Applicant Name – Last	Birth Date (m/d/yyyy)
Street Address	(Area Code) Telephone Number
City, State, ZIP Code	Email Address
☐ Yes ☐ No MV3141 *Driver Condition or Behavior Report* is enclosed	Internal WisDOT Use ONLY Issued by: Date:

License Applied For

☐ Class D ☐ Class M ☐ CDL ☐ School Bus ☐ Passenger

Minimum Standards see:
www.dot.state.wi.us/drivers/drivers/apply/vision.htm

VISION SPECIALIST: The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver licensing. Your report will be advisory in determining eligibility.

Indicate Snellen Chart Figures

Visual Acuity	Without RX	With RX	Temporal Field of Vision In Degrees
Right Eye	20/	20/	
Left Eye	20/	20/	

This report must be completed based on an examination conducted within the past 90 days or since: _____

YES NO

☐ ☐ 1. Does applicant have progressive eye condition(s)? If yes, what? _____

☐ ☐ 2. Is applicant able to distinguish traffic signal colors of red, amber and green?

3. Would you recommend:

☐ ☐ Driving evaluation with DMV (knowledge, signs and road test)
☐ ☐ No highway driving
☐ ☐ Limited radius driving. Miles from home: _____
☐ ☐ Daylight driving ONLY
☐ ☐ Other: _____

4. Do you feel the patient is safe to operate the following: (any recommendations are strictly advisory)

☐ ☐ Non-Commercial Vehicle
☐ ☐ Commercial Vehicle
☐ ☐ School and/or Passenger Bus

☐ ☐ 5. If applicable, I reviewed the attached Driver Condition or Behavior Report

☐ ☐ 6. Do you recommend any additional medical evaluation

Comments: _____

Specialist – Print Name	Check One: ☐ MD ☐ DO ☐ OD ☐ PA-C ☐ APNP	Medical License Number
Office Address, City, State, ZIP Code		(Area Code) Office Telephone Number
X (Specialist – Signature)	(Date – m/d/yyyy)	Patient Exam Date (m/d/yyyy)

Pursuant to s.448.01 and s.449.01 Wis. Statutes and Trans Ch. 112.02 Wis. Admin. Code, this form must be signed by an MD, DO, OD, PA-C or APNP.

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