



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	BREADTH OF VISION FIELD	
With Present Corrective Lenses	20/	20/	20/	To Right of Point of Fixation	To Left of Point of Fixation
Without Corrective Lenses	20/	20/	20/	_____	_____
Best Possible Correction	20/	20/	20/	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: