MATURE DRIVER VISION TEST

(This form is not valid after one year from date of examination.)

I hereby authorize (PRINT DOCTOR'S FULL NAME) _____
to give me this vision examination and to submit this report to the Division of Motorist Services.

_____ _____
Patient's Signature Driver License Number

_____ _____
Patient's Address, Street, and Number City/State-Zip

I AM A LICENSED PHYSICIAN AUTHORIZED TO PRACTICE UNDER CHAPTER 458, 459 OR 463, FLORIDA STATUTES, OR A LICENSED PHYSICIAN AT A FEDERALLY ESTABLISHED VETERANS' HOSPITAL AND CERTIFY THAT I HAVE PERSONALLY EXAMINED THE EYES OF

_____ _____
Patient's Name Date of Birth

AND THAT A TRUE RECORD OF THIS EXAMINATION APPEARS ON THE FORM BELOW, AND THAT SAID PATIENT SIGNED ABOVE IN MY PRESENCE.

Physician's License #_____ Signature of Physician _____

Date of Exam_____ Business Address _____

Telephone _____

NOTE: The Report of Eye Exam (HSMV 72010) must be used if: 1) the patient's visual acuity is 20/50 or worse in either eye, OR 2) there is any indication of eye disease or injury that would affect patient's driving ability.

DISTANT VISION ONLY	RIGHT EYE	LEFT EYE	BOTH EYES
VISION UNCORRECTED	20/	20/	20/
VISION WITH BEST CORRECTION	20/	20/	20/

FLORIDA MINIMUM VISUAL STANDARDS FOR LICENSING

20/50 or worse in either eye with or without corrective lenses are referred to an eye specialist for possible improvement.

130 degrees is the minimum acceptable field of vision.

The use of telescopic lenses to meet visual standards is not recognized in Florida.