Kentucky Career Center
Blind Services

Annual Visual Examination
for Kentucky Bioptic Driving Program

APPLICANT INFORMATION

Name:		Date of Birth:
Social Security Number:	Driver's License Number:	Expires:
Address:		Phone:
City:	State: **Kentucky**	Zip Code:

I authorize this information to be released to the Kentucky Office of Vocational Rehabilitation, the State Police and Transportation Cabinet.

Signature of Applicant: _____ Date: _____

RESULTS OF EYE EXAMINATION

Date of Exam:	Performed by:		
Visual Acuity Findings	**Without Correction**	**Best Correction (Carrier Lens)**	**Acuity with Telescope (Bioptic)**
OD (Right Eye)	20/_____	20/_____	20/_____ ; Power of Scope _____X
OS (Left Eye)	20/_____	20/_____	20/_____ ; Power of Scope _____X
Size of Visual Field (Use V4e isopter or equivalent) ***Note*** **Enclose copies of Visual Fields**	Instrument Used:		
Total Width (horizontal):	OD (Right Eye) _____degrees	OS (Left Eye) _____degrees	
Total Width (vertical):	OD (Right Eye) _____degrees	OS (Left Eye) _____degrees	
Over the next 12 months (1 year), patient's present level of vision is expected to: (please circle one)	Remain Stable Decline Improve		

Does patient's have a dark adaptation time so slow or a glare resistance and recovery time so slow as to render it difficult for him to see well driving at night or at twilight times? (please circle one)	YES	NO
Should this person be restricted to driving only during daylight?) (please circle one)	YES	NO
This patient already has a night driving license: (please circle one)	YES	NO
Color Perception adequate to recognize Traffic Signal Colors (red, green, amber)? (please circle one)	YES	NO
This patient is OK for Night Driving Evaluation, Training, and Testing: (please circle one) N/A	YES	NO

EXAMINER DATA (OPHTHALMOLOGIST OR OPTOMETRIST)

Name:		Degree:	
Address:		State:	Zip:
Signature:	Date:	Certification/License:	

OTHER RESTRICTIONS (COMPLETED BY THE KENTUCKY STATE POLICE BASED ON ROAD SKILLS TEST

Other Restrictions: (please circle all that apply)		
Use of Bioptic Telescopic Device	Day Time Driving	Other _____
Speed Under _____ mph	No Interstate Driving	_____ Mile Radius of Home
Reviewed by:		Date:

*****A copy of this document must accompany your driver's license at all times.*****