Kentucky Career Center
Blind Services

Visual Re-Examination
for Kentucky Bioptic Driving Program

APPLICANT INFORMATION

Name:		Date of Birth:
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 visual condition have a dark adaptation time so slow or a glare resistance and recovery time so slow as to render it difficult for them 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
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)	YES	NO

EXAMINER DATA (OPHTHALMOLOGIST OR OPTOMETRIST)

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

CERTIFICATION OF TRAINING (FOR NEW BIOPTIC DRIVERS ONLY)

I certify that the above individual has successfully completed a certified driver training program using a Bioptic Telescopic Device for driving.	
Signature of Bioptic Driving Instructor: _____	Program: **KY Bioptic Driving Program**

TO BE COMPLETED BY KY STATE POLICE DRIVER EXAMINER UPON SUCCESSFUL COMPLETION OF DRIVING 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
Signature of Examiner		Date:
Driver License Number:	Expires	

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