MINNESOTA DEPARTMENT OF PUBLIC SAFETY

Print Form

DRIVER AND VEHICLE SERVICES
445 Minnesota Street, Suite 180
Saint Paul, MN 55101-5180

Phone: (651) 296-6911 Fax: (651) 282-2463 TTY: (651) 282-6555
Web: dvs.dps.mn.gov Email: dvs.driverslicense@state.mn.us

Vision Report

- Section A - (Reverse Side) Must be completed and signed by patient in the presence of the vision examiner
- Section B - (Reverse Side) Must be completed and signed by a licensed vision examiner
- Minnesota statutes may require driving restrictions other than those recommended by the licensed vision examiner
- Submit the form:

  By mail: send to the address listed above
  By Fax: (651) 282-2463
  In person: Bring to any Driver's License Exam Station

DATA PRIVACY

All the information collected on this form is required by law. This data is used by authorized Driver and Vehicle Services division personnel to ensure that those with insufficient vision take the steps required to achieve the best vision possible and to deny driving privileges to those whose vision is likely to interfere with the safe operation of motor vehicles.
(Minnesota Statutes, chapters 171.04, 171.13, and 171.14; Minnesota Rule 7410.2400)

All data collected on this form is private and may not be issued to anyone, with the exception of name and address, which may be provided to law enforcement personnel.

A driver's license will not be issued until a satisfactory report is submitted.

Restriction Information - For complete information see Minnesota Rule 7410.2400

- **Daylight Restriction:** Visual acuity of 20/50 or less may be restricted to daylight hours.
- **Speed Restriction:** Visual acuity of 20/50 or less corrected vision in one usable eye or both eyes, or visual field of less than 105 degrees. *20/50: 55 miles per hour 20/60: 50 miles per hour 20/70: 45 miles per hour*
- **Area Restriction:** Visual acuity of 20/50 or less may be restricted to driving within a certain area equal to or less than the speed restriction. For example, a person limited to a maximum speed of 45 miles per hour or less is prohibited from driving on any freeway, expressway, or limited access highway that has a speed limit of more than 45 miles per hour.
- **Road Restriction:** Drivers with speed restrictions may also be restricted to driving on roads that have a speed limit.
- **Equipment Restriction:** Field of vision between 100 and 105 degrees in the horizontal diameter with either one usable eye or with both eyes - requires left and right outside rearview mirrors on vehicle.

COMPLETE REVERSE SIDE

SECTION A - TO BE COMPLETED BY PATIENT (Please Print)

MINNESOTA DRIVER'S LICENSE NUMBER: ☐-☐☐☐-☐☐☐-☐☐☐-☐☐☐ BIRTH DATE: ☐☐/☐☐/☐☐

Full Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

X _____ Phone Number: _____

Patient's Signature (**MUST** be signed in the presence of the vision examiner).

SECTION B - TO BE COMPLETED BY LICENSED VISION EXAMINER

Date of Last Vision Exam

Must have been within six months:

☐☐/☐☐/☐☐

Peripheral Vision

Horizontal Fields in Degree

Right Eye:	
Left Eye:	
Both Eyes:	

Vision Acuity

	Without Corrective Lenses	With Present Corrective Lenses	With New Corrected Lenses
Right Eye:	20/	20/	20/
Left Eye:	20/	20/	20/
Both Eyes:	20/	20/	20/

Is your patient's vision adequate to exercise reasonable and proper control of a motor vehicle? (Please check one)

☐ No, reason: _____

☐ Yes, without corrective lenses

☐ Yes, with present corrective lenses

☐ Yes, with new corrective lenses

Should your patient be required to have periodic visual exams? NO ☐ YES ☐ If yes, how often? _____

Recommended Restrictions: Please mark all that apply.

Daylight Only _____ Maximum Speed _____ mph Limit to _____ miles from home No Freeway Driving _____

Other (Specify) _____

VISION PROBLEMS

Please identify any condition that is impairing your patient's vision (i.e., cataracts present, macular degeneration, diabetic retinopathy, peripheral vision impairment, etc.). _____

What affect does your patient's condition have on his/her ability to see while driving? (i.e., tunnel vision, blurred vision, blank spots, etc.? _____

The condition is (please check one): STABLE ☐ PROGRESSIVE ☐

If your patient's vision is 20/80 or up to but not including 20/100, please answer following questions:

Is there treatment that would improve your patient's vision? NO ☐ YES ☐

Has treatment been scheduled? NO ☐ YES ☐ Anticipated date when treatment will be complete: _____/_____/_____

Vision Examiner's Name: _____ **License Number**: _____

Office Address: _____ Phone Number: _____

Street City State Zip Code

X _____

Vision Examiner's Signature Date