STATE OF KANSAS DIRECTOR OF VEHICLES
MEDICAL/VISION UNIT
300 SW 29th ST.
PO BOX 12021
TOPEKA KS 66601-2021

PLEASE RETURN COMPLETED VISION FORM TO:

PH: (785) 368-8971
FAX: (785) 296-5857
WEBSITE: KSREVENUE.GOV

KANSAS DIVISION OF VEHICLES VISION FORM

GENERAL INFORMATION & HISTORY – TO BE FILLED OUT BY THE PATIENT

Name: ____ Driver's License #: ______________ DOB: ____________

Address: ____ City/State/Zip: ______________________________

Phone Number: ____

Currently enrolled in Driver's Education? YES / NO If yes, instructor name & phone number: ______________________________

RELEASE OF INFORMATION

Permission is granted for release of all vision information concerning me to the Kansas Division of Vehicles by all vision and vision/medical professionals filling out this form. Minors may sign/date their own form or their Guardian may sign/date the form if the Minor is under 18 years of age.

____ ______________________________
SIGNATURE OF PATIENT/GUARDIAN (if patient under 18 years of age) DATE

SECTION I: VISION REPORT – TO BE FILLED OUT BY THE VISION PROFESSIONAL (K.S.A 8-295, 8-255c/K.A.R. 92-52-12)

The information on this form must be from an examination within the past 90 days (8-241(a)(1)).

	Distance Acuity Right Eye	Distance Acuity Left Eye
Visual Acuity Without Glasses/Contacts	20/______	20/______
Visual Acuity With Glasses/Contacts	20/______	20/______
Bioptic/Telescopic (for vision professional use)	20/______	20/______

(Bioptic/Telescopic readings are not used to determine issuance or drive test requirements)

Horizontal Field of Vision (in degrees)
Right Eye: _________________
Left Eye: _________________

Vision Condition Diagnosis: ____

Vision Condition Prognosis: ____

Provider Comments: ____

An annual vision report is recommended due to vision condition. ☐

As of the date of this vision exam, there is no reason to believe that the person's eyesight would preclude that person from operating a vehicle. (The box must be checked in order to continue driving privileges or to request an examiner drive test or driving rehabilitation assessment. A driving rehabilitation assessment may be requested by a doctor or as a result of a failed drive test.) ☐

Driver requires adaptive equipment to drive.	Yes ☐	No ☐
Do you recommend a drive test or driver education (if not licensed)?	Yes ☐	No ☐
Do you recommend this patient have a medical exam?	Yes ☐	No ☐

Indicate below which restrictions may apply to the patient's license if issued or continued: **Maximum 6 restrictions. Driver must use glasses or contacts for driving to add Corrective Lenses. <u>To remove a restriction(s) previously requested by a vision professional</u>, <u>please check the restriction box, and write "R" beside it.</u>**

☐ Corrective Lenses	☐ Daylight Hours Only	☐ No Interstate Driving	☐ Outside Business Area
☐ Within City Limits	☐ Licensed Driver in Front Seat	☐ Automatic Transmission	☐ Outside Mirror
☐ Mechanical Aid	☐ Prosthetic Aid	☐ ________Miles From Home (**5-30 in 5 mile increments**)	

____
Name of Vision Professional (please print) & Specialty

____
Date of Examination (within past 90 days or 6 months after a seizure occurred)

____
Address

____
Signature of Vision Professional

____
Phone

____
Date Signed

DV-124V (Rev 01 23)