STATE OF KANSAS DIRECTOR OF VEHICLES

PLEASE RETURN COMPLETED VISION FORM TO:

MEDICAL/VISION UNIT
300 SW 29th ST.
PO BOX 2188
TOPEKA KS 66601-2188

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/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).

	Acuity Right Eye	Acuity Left Eye	Horizontal Field of Vision
Visual Acuity Without Glasses/Contacts	20/_____	20/_____	
Visual Acuity With Glasses/Contacts	20/_____	20/_____	Equal to or greater than 20°?
Bioptic/Telescopic (for vision specialist use only)	20/_____	20/_____	
(The Bioptic/Telescopic readings are not used to determine issuance or drive test requirements)			Yes ☐ No ☐

Vision Condition Diagnosis: _____

Vision Condition Prognosis: _____

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

Corrective eyewear (glasses/contacts) are recommended to be worn when driving. ☐

Driver requires adaptive equipment to drive.	Yes ☐	No ☐
Does this patient require a drive test or driver education (if not licensed)?	Yes ☐	No ☐
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.	Yes ☐	No ☐
(The answer to this question must be "yes" in order 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.)		
Do you recommend this patient have a medical exam?	Yes ☐	No ☐

DL#

Indicate below which restrictions may apply to the patient's license if issued or continued: **Maximum 6 restrictions.**

To remove a restriction(s) previously requested by a vision professional, please check the restriction box, and write "R" beside it.

☐ 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)	

If **Mechanical Aid is required for driving**, please advise what type: _____

If **Prosthetic Aid is required for driving**, please advise if right side, left side or both: _____

Provider Comments: _____

_____

Name of Vision Professional (Please print)	Date of Examination (within past 90 days or 6 months after a seizure occurred)
Address	Signature of Vision Professional
Phone	Date Signed