U.S. Department of Transportation Federal Motor Carrier Safety Administration

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VISION EVALUATION REPORT

Name:	DOB:	
Driver's License Number:	State:	

Information for the Individual:

The medical examiner must receive this report and begin the physical qualification examination not more than **45** calendar days after an ophthalmologist or optometrist signs this report.

Information for the Ophthalmologist or Optometrist:

This individual is being evaluated as part of the process to determine whether the individual meets the vision standard of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle in interstate commerce. This report is required to provide information for an individual who has "monocular vision," as defined by FMCSA, or did not meet FMCSA's vision standard at a physical qualification examination. An ophthalmologist or optometrist should complete this report to the best of the ophthalmologist's or optometrist's ability based on the evaluation of the individual and knowledge of the individual's medical history. The determination as to whether the individual meets the vision standard and is physically qualified to drive a commercial motor vehicle will be made by a medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines monocular vision as:

- (1) in the better eye, distant visual acuity of at least 20/40 (with or without corrective lenses) and field of vision of at least 70 degrees in the horizontal meridian; and
- (2) in the worse eye, either distant visual acuity of less than 20/40 with corrective lenses or field of vision of less than 70 degrees in the horizontal meridian, or both.

For general informational purposes only, to meet FMCSA's monocular vision standard, an individual must:

- (1) have in the better eye distant visual acuity of at least 20/40 (Snellen), with or without corrective lenses, and field of vision of at least 70 degrees in the horizontal meridian;
- (2) be able to recognize the colors of traffic signals and devices showing standard red, green, and amber;
- (3) have a stable vision deficiency; and
- (4) have had sufficient time pass since the vision deficiency became stable to adapt to and compensate for the change in vision.

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Nam	e: DOB:			
PLEASE CHECK/FILL IN REQUESTED INFORMATION (PLEASE PRINT):				
1.	I am: an ophthalmologist an optometrist			
2.	Date of vision evaluation (MM/DD/YYYY):			
3.	Distant visual acuity (select N/A if there is no vision in an eye): Uncorrected: Right eye: 20/ or N/A Left eye: 20/ or N/A Corrected: Right eye: 20/ or N/A Left eye: 20/ or N/A Type of correction: Glasses Contacts			
4.	 Field of vision, including central and peripheral fields, utilizing a testing modality that tests to at least 120 degrees in the horizontal. Formal perimetry is required. Attach a copy of the formal perimetry test for each eye and interpret the results in degrees of field of vision. Right eye: degrees ("normal" or "full" are not acceptable) Left eye: degrees ("normal" or "full" are not acceptable) Test used to determine results: ATTACHFILE 			
5.	Is the individual able to recognize the standard red, green, and amber traffic control signal colors? 🗌 Yes 🗌 No			
6.	Date of last comprehensive eye examination (MM/DD/YYYY): or Date unknown			
7.	Does the individual have monocular vision as it is defined by FMCSA? Yes No If yes, cause of the monocular vision (describe):			
8.	Date the monocular vision began (MM/DD/YYYY):			
9.	Current treatment: or DV/A			
10.	Does the individual have any progressive eye condition or disease (e.g., macular edema, cataracts, glaucoma, or retinopathy)?			
	Yes No			
	If yes, provide the condition or disease, date of diagnosis, severity (mild, moderate, or severe), current treatment, and whether the condition is stable: a. Condition or disease:			
	Date of diagnosis: Severity: Dild Didderate Severe Current treatment:			
	Is condition stable? Yes No If no, why:			

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Form MCSA-5871		OMB No.: 2126-0006
	artment of Transportation Motor Carrier Safety Administration	Expiration Date: 03/31/2025
Name: _	DOB:	
b.	Condition or disease:	
	Date of diagnosis:	Severity: Mild Moderate Severe
	Is condition stable? Yes No	If no, why:
c.	Condition or disease:	
		Severity: Mild Moderate Severe
	Is condition stable? 🗌 Yes 🗌 No	If no, why:
11. In	your medical opinion, is the individual's	vision deficiency stable? 🗌 Yes 🗌 No
If	yes, provide the date the vision deficient	cy became stable (MM/DD/YYYY):
ada		he passed since the vision deficiency became stable to allow the individual to vision and to drive a commercial motor vehicle safely?
13. In	your medical opinion, is a vision evaluat	tion required more often than annually? 🗌 Yes 🗌 No
If	yes, how often and why?	
14. Ad	ditional comments (attach additional po	iges as needed)
		ATTACH FILE
	t that I am an ophthalmologist or opt f my knowledge.	cometrist and that the information provided is true and correct to the
Date		Printed Name and Medical Credential
Profess	ional License Number and State	Signature

Duc	
Professional License Number and State	Signature
Phone Number	Email
Street Address	City, State, Zip Code

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