Vision Evaluation Checklist

Federal Diabetes Exemption Program

Driver Identifying Information

Name: _____
First MI Last
Address:_____

DOB (MM/DD/YYYY): _____

This applicant is applying for a Federal diabetes exemption to be able to take insulin while operating a commercial motor vehicle (large truck or bus) in interstate commerce. Part of the application process is an eye examination by an ophthalmologist or optometrist to determine if the individual has any vision problem that might impair safe driving.
NOTE: If the applicant has retinopathy, an ophthalmologist examination is required.

The applicant's examination by an ophthalmologist or an optometrist is only valid for 6 months from the date performed. Applicants will be required to submit a new examination if the current examination expires during the application process.

PLEASE CHECK / FILL IN REQUESTED INFORMATION.

1. ☐ I am an ophthalmologist ☐ I am an optometrist

   Office Telephone number: _____ Office Fax number: _____

2. Date of most recent examination: _____ (MM/DD/YYYY)

3. Distant visual acuity (**please provide both if applicable**):
   ☐ UNCORRECTED ☐ CORRECTED
   ☐Glasses
   ☐Contact Lens

   Right eye: 20/_____ Right eye: 20/_____
   Left eye: 20/_____ Left eye: 20/_____

4. Field of vision (FOV)*:
   Please record the interpreted results in **degrees** of horizontal field of vision for each eye. The terms "normal" or "full" are not acceptable responses.

   Right eye: _____degrees
   Left eye: _____degrees
   Test used to determine: _____

***Note:** If the patient has received laser treatment, and in your medical opinion you believe the patient's FOV is compromised, FMCSA recommends formal perimetry to determine if the driver meets the FOV standard.

5. Color Vision:
   Is the patient able to identify correctly the standard red, green, and amber traffic control signal colors? ☐ YES ☐ NO

Note: If color testing results are inconclusive, it is discretionary whether to administer a controlled test using an actual traffic signal to determine the individual's ability to recognize red, green, and amber.

An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/procedures (postoperatively).

6. Does the patient have diabetic retinopathy? ☐ YES ☐ NO

   If yes: ☐ Proliferative
   O Stable O Unstable
   ☐ Nonproliferative
   O Stable O Unstable
   Treatment: _____
   Date diagnosed: _____
   Surgery/procedures: _____
   Requires recheck in ____ months

7. Does the patient have macular edema?
   ☐ YES ☐ NO

8. Does the patient have cataract(s)?
   ☐ YES ☐ NO

9 Does the patient have any other medical diagnosis related to vision?
   ☐ YES ☐ NO

   If yes, what? _____

10. If yes to any of the conditions listed above, are any unstable?
   ☐ YES ☐ NO

   If yes, which condition(s)? _____

11. In your medical opinion, is monitoring required more often than annually?
   ☐ YES ☐ NO

   If yes, how often? _____

12. **Please attach your office letterhead with your printed/typed name, signature, date, license number, date of expiration and state of issue to this checklist.**