



CUSTOMER MEDICAL REPORT

Purpose: Use this form to request medical information from your physician, physician assistant or nurse practitioner.

Instructions: Follow the detailed INSTRUCTIONS printed on page 2. Complete the Customer Information and Information Release Approval sections on this page. Take the entire MED 2 and DMV letter to your physician, physician assistant or nurse practitioner to complete the sections that pertain to your medical condition. Part F must be completed by your physician, physician assistant or nurse practitioner. Note: Any charges related to or incurred as part of the completion of this form are the customer's responsibility.

CUSTOMER INFORMATION					
NAME (Last)	(First)	(MI)	(Suffix)	CUSTOMER NUMBER (from your driver's license) or SSN	
NOTE: If you enter a residence or mailing address that is other than what is currently on DMV's system, complete an "Address Change Request" (ISD 01).					
RESIDENCE/HOME ADDRESS					
CITY	STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE		
MAILING ADDRESS					
CITY	STATE	ZIP CODE			
DAYTIME TELEPHONE NUMBER	BIRTH DATE (mm/dd/yyyy)	WEIGHT	lbs	HEIGHT	FT IN
Describe, in detail, your medical condition.					
Do you take prescription/non-prescription medications? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, list below. (attach a separate sheet if more space is required)					
NON-PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN	PRESCRIPTION MEDICATION	DOSAGE	TIME(S) TAKEN
Have you ever experienced a blackout, seizure, loss of consciousness, or syncope? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, enter date of last episode.		DATE (mm/dd/yyyy)	Did the episode result in a motor vehicle crash? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Explain what happened during the episode.					

COMMERCIAL DRIVER'S LICENSE DISABILITY WAIVER OR HAZARDOUS MATERIALS VARIANCE

Are you applying for a commercial driver license disability waiver or a hazardous materials variance? YES NO
If YES, a CDL Disability Waiver or Hazardous Materials Variance Application (MED 30) must also be submitted.

INFORMATION RELEASE APPROVAL

I authorize _____ and/or _____, a licensed medical provider to complete this Customer Medical Report, submit it to DMV and, if necessary to provide further clarification or information to DMV about my physical and/or mental condition. I consent to DMV using this information to arrive at a decision concerning my ability to safely operate a motor vehicle. I also authorize DMV to use the above customer information to correctly identify my records on file in accordance with the Virginia Privacy Protection Act of 1976. I understand that Virginia Code § 46.2-208(b)(1) prohibits DMV from releasing medical data to anyone other than a physician, physician assistant or nurse practitioner

CUSTOMER SIGNATURE AND AUTHORIZATION (parent must sign for a minor)

DATE (mm/dd/yyyy)



CUSTOMER MEDICAL REPORT INSTRUCTIONS

Purpose: Use these instructions to complete the Customer Medical Report (MED 2).

CUSTOMER INSTRUCTIONS

1. Review all correspondence received from the Department of Motor Vehicles (DMV) regarding concerns about your ability to safely operate a motor vehicle.
 - If you received an Official Notice/Order of Suspension, you must provide DMV with the required Customer Medical Report (MED 2), prior to the effective date noted in the Notice/Order to avoid having your driving privilege suspended.
 - If your driving privilege is suspended, you will be required to provide proof of legal presence in order to reinstate your driver's license, if you have not already provided proof.
2. Complete the sections of the MED 2 titled "Customer Information" and "Information Release Approval". Be sure to provide your signature at the end of the "Information Release Approval" section.
3. Take the entire MED 2 and your **DMV letter to your medical provider at the time of your medical examination.**
4. Request your medical provider to complete the parts of the MED 2 that pertain to your medical condition(s) **and** Part F and return the report to DMV (following medical provider instructions below).
 - The medical examination must be conducted after the issue date of your Official Notice/Order of Suspension.
 - If you were involved in a recent motor vehicle crash or have experienced a recent blackout, seizure or loss of consciousness, the MED 2 report must reference these incidents and/or events.

Note: you will be notified of any decisions regarding your driving privilege based on:

 - Medical and other related information received from your medical provider,
 - DMV driver license test results and/or a certified independent driver rehabilitation evaluation (if required),
 - DMV medical review policies and guidelines as established in collaboration with the DMV Medical Advisory Board.
5. If you have questions related to DMV's requirement for you to submit a MED 2, you may contact DMV Medical Review Services:
 - Mail - send your request in writing to Medical Review Services at the address listed at the top of this form
 - Telephone - (Voice) 1-804-367-6203 or (Deaf/Hearing Impaired only) 1-800-272-9268

CUSTOMER MEDICAL REPORT INSTRUCTIONS

MEDICAL PROVIDER INSTRUCTIONS

1. The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
 - level of consciousness/alertness
 - vision/perception
 - motor skills/range of motion
 - judgment/cognitive function
 - reaction time
2. DMV may have requested these documents for one of three reasons:
 - DMV received a crash report, Medical Review Request Form, or a court document that requires a medical evaluation. Please refer to the customer explanation letter that describes the issue of concern that needs to be addressed. Each form, A-E, has a section to complete regarding the issue. Please supply a medical opinion on the area of concern and attach any relevant lab work or test results.

If your patient was involved in a recent motor vehicle crash or has experienced a recent blackout, loss of consciousness, or seizure, the MED 2 must include specific information that may have contributed to the incident(s) and/or event(s).
 - DMV is requesting these forms for a patient we have under periodic review. Please be sure to address the patient's ongoing stability, any episode of instability, or any decline in the patient's condition. Please note any new conditions that may interfere with safe driving.
 - A patient self-reported on their application a medical condition or a medication that may indicate a medical condition that DMV evaluates for driver safety.
3. Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s).
 - For medical conditions, complete one or more of the following specific report sections:
 - Neurological/Musculoskeletal - Part A & F
 - Metabolic - Part B & F
 - Cardiovascular - Part C & F
 - Pulmonary - Part D & F
 - Psychiatric/Substance Abuse - Part E & F

NOTE: Only one Part F is required if the same medical provider completes multiple report sections.
4. In lieu of completing the MED 2, you may submit a letter, note or copies of records as long as the information you submit addresses all of the information requested on the MED 2 including your determination on the patient's ability and safety to drive.
5. Return the completed MED 2 to DMV by faxing it to DMV Medical Review Services at (804) 367-1604.
6. For additional information on DMV's medical review process, you may refer to www.dmvnow.com under "Citizen Services", then "Medical Information", or contact Medical Review Services at 804-367-6203.

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
 level of consciousness/alertness vision/perception motor skills/range of motion judgment/cognitive function reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART A - NEUROLOGICAL/ MUSCULOSKELETAL REPORT (must also complete Part F)

<input type="checkbox"/> N/A for this customer		
Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
DIAGNOSIS(ES) (In order of severity or by current treatment)		
Are there any complications related to this/these condition(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain.		
Has the patient been hospitalized for the above condition(s) within the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, list dates hospitalized and status upon discharge.		
Does the patient have a history of seizures? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, provide date of each episode and reason(s).		
Indicate the risk for further episodes.		
Did any seizure result in a motor vehicle crash? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, enter date of crash.	DATE OF CRASH (mm/dd/yyyy)	
Was the most recent anticonvulsant drug serum level within acceptable range? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, provide results of blood test.	BLOOD TEST RESULTS	
Did the patient have a blackout or syncope? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, what was the cause? (Please enclose documentation to support the cause; such as results of lab work and blood pressures to support dehydration, high fever, etc.)		
Results of most recent EEG		
Does the patient have any motor deficits/nerve problems that would impair his/her ability to drive? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does the patient have any other neurological condition(s) that might affect his/her driving? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, describe the condition(s) and its effect on the patient's driving.		
Is the patient prescribed medication for chronic pain or long-acting narcotics? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, list the medication(s).		
Does the patient have the use of all extremities? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, which extremities are impaired?		
Does the patient suffer from peripheral neuropathy? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, which extremities are impaired?		
Does the neuropathy affect the patient's ability to safely operate a motor vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Does the patient have full range of motion of the head and neck? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, describe range of motion.		
Is adaptive equipment recommended? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, what type of adaptive equipment does the patient require?		
If your patient is being seen for a particular incident, crash, or report provided to DMV, please provide relevant specific contributing information here.		

Go to Part F

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
 level of consciousness/alertness vision/perception motor skills/range of motion judgment/cognitive function reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART B - METABOLIC REPORT (must also complete Part F)

N/A for this customer

Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
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DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? YES NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? YES NO If Yes, list dates hospitalized and status upon discharge.

Does this patient have hypoglycemic reactions? YES NO If Yes, provide dates and reasons.

Did the hypoglycemic reaction(s) result in a motor vehicle crash(es)? YES NO

Does this patient demonstrate how to counter a hypoglycemic reaction? YES NO If Yes, explain how.

Does the patient monitor his/her blood sugar? YES NO If Yes, how often?

Attach the following information/documents. If you suffered a hypoglycemic event, please ensure that your blood sugar logs reflect the last 15 days and your A1C results are drawn after the incident occurred and within the last 30 days.

Blood Sugar Logs (15 days) Attached

Hemoglobin A1C Results (30 days) Attached

If your patient is being seen for a particular incident, crash , or report provided to DMV, please provide relevant specific contributing information here.

Go to Part F

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
 level of consciousness/alertness vision/perception motor skills/range of motion judgment/cognitive function reaction time
 Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART C - CARDIOVASCULAR REPORT (must also complete Part F)

<input type="checkbox"/> N/A for this customer		
Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
DIAGNOSIS(ES) (In order of severity or by current treatment)		
Are there any complications related to this/these condition(s)? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain.		
Has the patient been hospitalized for the above condition(s) within the past year? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, list dates hospitalized and status upon discharge.		

Does the patient have an implantable cardioverter defibrillator? YES NO If Yes, give implant date.

Has the unit discharged since the implant? YES NO If Yes, describe the patient's condition at the time and date of discharge.

Does the patient have a ventricular assist device system? YES NO If Yes, when was this device implanted?

Has the patient had any of the following:

Cardiovascular surgery and/or other procedures? YES NO If Yes, explain and give dates.

Syncope? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain and give dates.	Attach the following information/documents: <input type="checkbox"/> Results of Event Monitor <input type="checkbox"/> Results of Holter Monitor <input type="checkbox"/> Results of Tilt-table Test <input type="checkbox"/> Results of EKG
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Does this patient have congestive heart failure? YES NO

Does this patient have decompensated CHF? YES NO

If yes, is it STABLE NOT STABLE

Does this patient have angina? YES NO

If yes, is it STABLE NOT STABLE

If your patient is being seen for a particular incident, crash , or report provided to DMV, please provide relevant specific contributing information here.

Go to Part F

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
 level of consciousness/alertness vision/perception motor skills/range of motion judgment/cognitive function reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART D - PULMONARY REPORT (must also complete Part F)

N/A for this customer

Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
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DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? YES NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? YES NO If Yes, list dates hospitalized and status upon discharge.

Is oxygen use required? YES NO If Yes, describe treatment regimen and provide number of liters.

Fatigue with exertion? YES NO Fatigue at rest? YES NO

Dyspnea with exertion? YES NO If Yes, explain and give dates.

Dyspnea at rest? YES NO If Yes, explain and give dates.

Syncope from cough? YES NO If Yes, explain cause and resolution.

Does the patient have a diagnosis of sleep apnea, narcolepsy, or other sleep disorder?
 YES mild moderate severe (describe the treatment and submit a CPAP report for moderate to severe sleep apnea).
 NO

Does the pulmonary disease prevent activities of daily living? YES NO If Yes, identify.

Has patient been compliant with treatment to the extent that the symptoms are controlled? YES NO

Pulse oximetry room air oxygen

Can the patient maintain O2 Saturation level of 88% or higher? YES NO

Attach the following information/document if available
 Results of pulmonary function test
 Results of sleep study

If your patient is being seen for a particular incident, crash , or report provided to DMV, please provide relevant specific contributing information here.

Go to Part F

Customer Medical Report

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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The Department of Motor Vehicles (DMV) is seeking information that will allow us to make a decision regarding your patient's ability to safely operate a regular motor vehicle and/or commercial motor vehicle. DMV is concerned about any condition(s) and/or use of medication(s) which may result in impaired:
 level of consciousness/alertness vision/perception motor skills/range of motion judgment/cognitive function reaction time

Based on the examination that you conduct, please complete the parts of the MED 2 that pertain to your patient's medical condition(s) and Part F.

PART E - PSYCHIATRIC/SUBSTANCE ABUSE REPORT (must also complete Part F)

N/A for this customer

Length of time individual has been your patient. YEARS _____ MONTHS _____	Have you examined this individual during the last six months? <input type="checkbox"/> YES <input type="checkbox"/> NO IF Yes, enter examination date.	EXAMINATION DATE (mm/dd/yyyy)
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DIAGNOSIS(ES) (In order of severity or by current treatment)

Are there any complications related to this/these condition(s)? YES NO If Yes, explain.

Has the patient been hospitalized for the above condition(s) within the past year? YES NO If Yes, list dates hospitalized and status upon discharge.

Was the hospitalization voluntary? YES NO

Does the patient have a condition, which results in one or more of the impairments listed below? YES NO If Yes, check all that apply.

<input type="checkbox"/> Poor decision-making/problem-solving skills	<input type="checkbox"/> Hallucinations/delusions	<input type="checkbox"/> Poor/impaired judgement
<input type="checkbox"/> Memory loss, Cognitive	<input type="checkbox"/> Extremely aggressive/destructive behavior	<input type="checkbox"/> Dementia/confusion
<input type="checkbox"/> Poor impulse control/extremely impulsive	<input type="checkbox"/> Emotional or behavioral instability	

Identify current treatment program(s), counseling, medications, etc.

Attach the following information/documents, (if indicated):
 MMSE attached not available
 Neuropsychological Exam attached not available

Is patient CURRENTLY undergoing OR has patient successfully completed drug/alcohol treatment? YES NO If Yes, please provide name of program.

Has the patient been compliant with substance abuse treatment? YES NO

Attach the following information/documents:
 Results of drug/alcohol screening
 Report from substance abuse counselor
 Recommendations:

Did the patient experience seizure(s) related to withdrawal? YES NO If Yes, give date(s).

If your patient is being seen for a particular incident, crash , or report provided to DMV, please provide relevant specific contributing information here.

Customer Medical Report

(MUST BE COMPLETED BY PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER)

NAME (Last)	(First)	(MI)	(Suffix)	BIRTH DATE (mm/dd/yyyy)	CUSTOMER NUMBER or SSN
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PART F - GENERAL RECOMMENDATIONS

DMV will review the recommendations below and make a Final determination for driving.

Is the patient's condition(s) stable? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain.	Is the patient compliant with treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain:
Does the patient experience side effects of medications, which are likely to impair driving ability? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain:	
Check if individual is medically unsafe to drive <input type="checkbox"/>	
Based on this examination, is the patient medically capable of: ▪ safely operating a commercial motor vehicle includes tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Based on this examination, patient needs the following: (check each appropriate item) <input type="checkbox"/> a driver evaluation (with a certified independent driver rehabilitation specialist CDRS). <input type="checkbox"/> an adaptive device/equipment required to safely operate a motor vehicle. <input type="checkbox"/> a prosthetic/orthotic device to operate a motor vehicle	
For clarification on any of the above, contact Medical Review Services at 804 367-6203.	
Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)	
Judgment and Insight <input type="checkbox"/> Problem Solving and Decision Making <input type="checkbox"/> Cognitive Function	Sensorimotor Function <input type="checkbox"/> Strength and Endurance <input type="checkbox"/> Maneuvering Skills
<input type="checkbox"/> Emotional or Behavioral Stability <input type="checkbox"/> Reaction Time	<input type="checkbox"/> Range of Motion <input type="checkbox"/> Use of Arm(s) and/or Leg(s)
ADDITIONAL RECOMMENDED RESTRICTIONS	MEDICATIONS
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)	MEDICAL SPECIALTY
MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)
ISSUING STATE	TELEPHONE NUMBER ()
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE	FAX NUMBER ()
DATE (mm/dd/yyyy)	

If you have questions or need more information to complete this page, call Medical Review Services (804) 367- 6203.

DMV will review the recommendations below and make a Final determination for driving.

Is the patient's condition(s) stable? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain.	Is the patient compliant with treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO If No, explain:
Does the patient experience side effects of medications, which are likely to impair driving ability? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, explain:	
Check if individual is medically unsafe to drive <input type="checkbox"/>	
Based on this examination, is the patient medically capable of: ▪ safely operating a commercial motor vehicle includes tractor trailers, passenger buses, tank vehicles, school buses for 16 or more occupants (including the driver), or vehicles carrying hazardous materials? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Based on this examination, patient needs the following: (check each appropriate item) <input type="checkbox"/> a driver evaluation (with a certified independent driver rehabilitation specialist CDRS). <input type="checkbox"/> an adaptive device/equipment required to safely operate a motor vehicle. <input type="checkbox"/> a prosthetic/orthotic device to operate a motor vehicle	
For clarification on any of the above, contact Medical Review Services at 804 367-6203.	
Based on this examination, the patient's driving ability is likely to be impaired by limitations in the following areas: (check each appropriate item)	
Judgment and Insight <input type="checkbox"/> Problem Solving and Decision Making <input type="checkbox"/> Cognitive Function	Sensorimotor Function <input type="checkbox"/> Strength and Endurance <input type="checkbox"/> Maneuvering Skills
<input type="checkbox"/> Emotional or Behavioral Stability <input type="checkbox"/> Reaction Time	<input type="checkbox"/> Range of Motion <input type="checkbox"/> Use of Arm(s) and/or Leg(s)
ADDITIONAL RECOMMENDED RESTRICTIONS	MEDICATIONS
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER NAME (print)	MEDICAL SPECIALTY
MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)
ISSUING STATE	TELEPHONE NUMBER ()
PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER SIGNATURE	FAX NUMBER ()
DATE (mm/dd/yyyy)	

CUSTOMER VISION REPORT

Purpose: Use this form to request vision examination information from your ophthalmologist or optometrist.

Instructions: Complete the Customer Information section and have your Ophthalmologist/Optomtrist complete the Vision Examination section. The vision examination must be conducted within 90 days prior to submission of the report to DMV. Mail the completed report to the address above. Questions can be referred to Medical Review Services, 804-367-6203. Acceptable standards of vision for safe driving are determined by the Code of Virginia and DMV under the guidance of the Medical Advisory Board.

Note: Any charges incurred for the completion of this form are your responsibility.

CSC STAFF Do NOT send MED 4 back with daily work unless there is an ocular condition or customer cannot be licensed due to a MED 6 calculation.

CUSTOMER INFORMATION (To be completed by customer PRIOR to vision examination)

If you change either your residence/home address or mailing address to a non-Virginia address, your driver license or photo identification (ID) card may be cancelled.

NAME (last)	(first)	(mi)	(suffix)	CUSTOMER NUMBER (from your driver license) or SSN
RESIDENCE/HOME ADDRESS				BIRTHDATE (mm/dd/yyyy)
CITY		STATE	ZIP CODE	CITY OR COUNTY OF RESIDENCE
MAILING ADDRESS (if different from above)				
CITY		STATE	ZIP CODE	DAYTIME TELEPHONE NUMBER ()

VISION EXAMINATION (to be completed by Ophthalmologist/Optomtrist)

FIRST EXAMINATION DATE	MOST RECENT EXAMINATION DATE
Does the patient have any visual/ocular condition(s) that could affect the ability to drive a motor vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, indicate condition below.	
Does the patient have any condition that would affect the peripheral visual field? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please provide a graphic visual field analysis to 120 degrees total in each eye. Preferably a HVF 30-2 AND 60-4 or other threshold perimetry test (see Note C on page 2 for the list of conditions requiring a Visual Field).	
PLEASE LIST ALL VISUAL/OCULAR CONDITION(S)	
PROVIDER COMMENTS	

VISUAL MEASUREMENTS

Check applicable: Vision in both eyes Vision Limited to RIGHT EYE (OD) ONLY Vision Limited to LEFT EYE (OS) ONLY

VISUAL ACUITY (See Note "A" on page 2)			HORIZONTAL VISUAL FIELD (fields must be in degrees)				
Uncorrected Visual Acuity	RIGHT EYE (OD)	LEFT EYE (OS)	BOTH EYES (OU)	DMV Visual Field information: See Note C on page 2.			
	20/	20/	20/	METHOD: (check one) <input type="checkbox"/> CONFRONTATION <input type="checkbox"/> AUTOMATED			
Best Corrected Visual Acuity	RIGHT EYE (OD)	LEFT EYE (OS)	BOTH EYES (OU)	TEMPORAL - OD	NASAL - OD	TEMPORAL - OS	NASAL - OS
	20/	20/	20/	0-100 (degrees)	0-60 (degrees)	0-100 (degrees)	0-60 (degrees)

OPHTHALMOLOGIST/OPTOMETRIST CERTIFICATION

PROVIDER: Please FAX abnormal results to Medical Review Services, 804-367-1604.

MEDICAL PROVIDER NAME (print)	CHECK BOX THAT APPLIES: <input type="checkbox"/> OPHTHALMOLOGIST <input type="checkbox"/> OPTOMETRIST		
MEDICAL LICENSE NUMBER	EXPIRATION DATE (mm/dd/yyyy)	STATE ISSUING LICENSE TO PRACTICE	
BUSINESS ADDRESS			TELEPHONE NUMBER ()
CITY	STATE	ZIP CODE	FAX NUMBER ()
MEDICAL PROVIDER SIGNATURE			DATE (mm/dd/yyyy)

NOTES

- A Acuity:** Visual Acuity should be recorded at the lowest line where an individual scores 100% correct. Whole numbers only. Visual requirements must be met without the aid of a telescopic lens. Some drivers may be granted waivers from these vision requirements.
- B. CDL Waiver:** Holders of or applicants for a Commercial Driver's License (CDL) or Commercial Learner's Permit (CLP), who are unable to meet Virginia minimum vision requirements may apply to DMV's Medical Review Services for a disability waiver to qualify for an intrastate only CDL or CLP, provided they meet the Federal Motor Carrier Safety Administration Regulations' minimum vision requirements. Color perception is required. Please have your eye care practitioner submit a graphic visual field analysis to 120 degrees in each eye.
- C. Visual Field (VF):** Individuals who have a high-risk condition that can reduce the usable field of vision should have a baseline Visual Field Analysis (VFA) performed. Conditions that are progressive, such as retinitis pigmentosa and glaucoma, will be reviewed by DMV annually. Repeat VF testing will be requested when changes are reported in the visual field or at a minimum of every 3 years.

High Risk Ophthalmic Conditions Requiring a Visual Field Analysis:

- Hemianopia (complete) and Quadrantanopia (complete). Partial hemianopic and quadrantanopic defects may be considered safe for driving if the individual demonstrates an adequate field of vision in the unaffected side and the affected side retains or regains 30 degrees temporally with 15 degrees above and below the horizontal line for the full 30 degrees.
- Bitemporal hemianopia may drive if combined nasal measurement meets the Virginia standard for horizontal vision of 40 degrees to one side and 30 degrees to the other side for a minimum of 70 degrees total as demonstrated by VFA.
- Other visual field loss from strokes, tumors or compressive disorders
- Glaucoma - Moderate to Severe stage
- Ischemic, traumatic, compressive, toxic , hereditary (Lebers) or malnutrition related optic neuropathy
- Optic neuritis
- Optic nerve head edema - papilledema
- Optic atrophy
- Proliferative diabetic retinopathy status post pan retinal photocoagulation
- Retinitis pigmentosa
- Retinal ischemia due to artery or vein occlusions and uveitis etiologies
- Retinal detachment
- Retinal laser procedures
- History of retinopathy of prematurity or radiation retinopathy

Measuring Visual Fields for DMV Vision Reports:

- To determine visual field loss, DMV requires the results of a visual field test that measures the central 24 to 30 degrees of the visual field; that is, the area measuring 24 to 30 degrees from the point of fixation. Acceptable tests include the Humphrey Field Analyzer (HFA) 30-2, HFA 24-2, Octopus 32 or equivalent threshold perimetry test. In addition, testing needs to be completed to 120 degrees (60 degrees from the point of fixation) i.e. HVF 60-4 or equivalent.
- Screening tests: DMV will not accept the results of visual field screening tests, such as confrontation tests, tangent screen tests, or automated static screening tests, to determine if the visual field meets DMV requirements when an individual has a condition that places them at high risk for visual field loss.
- Use of corrective lenses: Eyeglasses should not be worn during visual field testing because they limit the field of vision. Individuals may wear contact lenses to correct visual acuity during the visual field test to obtain the most accurate visual field measurements.
- Scotoma: A scotoma is a field defect or non-seeing area (also referred to as a "blind spot") in the visual field surrounded by a normal field or seeing area. When measuring the visual field, subtract the length of any scotoma, other than the normal blind spot, from the overall length of any diameter on which it falls.

VISION STANDARDS

DRIVER'S LICENSE:

- ▶ 20/40 or better vision in one or both eyes, *and*
- ▶ 110 degrees, or better, horizontal vision in one or both eyes.

RESTRICTED TO DAYLIGHT HOURS ONLY:

- ▶ 20/70 or better vision in one or both eyes, *and*
- ▶ 70 degrees, or better, horizontal vision.
- If vision is limited to only one eye, 40 degrees or better temporal and 30 degrees or better nasal are required.

**COMMERCIAL DRIVER'S LICENSE:
(See Note "B" on page 2)**

- ▶ 20/40 or better vision in each eye
- ▶ 140 degrees or better horizontal vision