

**SOUTH DAKOTA DEPARTMENT OF  
PUBLIC SAFETY  
DRIVER LICENSING PROGRAM  
VISION STATEMENT**

Name of Applicant: \_\_\_\_\_ DL#: \_\_\_\_\_

Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Permission is hereby granted for the release of the medical data below and other medical history applicable in my case to the South Dakota Department of Public Safety, Driver Licensing Program.

I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct. Any false statement or concealment of any material facts subjects any license issued to immediate cancellation.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EYE EXAMINATION: This portion must be completed by a licensed optometrist or ophthalmologist:  
Please answer all questions (leave no blanks).**

DISTANCE VISUAL ACUITY:	<u>Both Eyes Together</u>	<u>Right Eye</u>	<u>Left Eye</u>
Without Lenses	20/	20/	20/
With Present Lenses	20/	20/	20/
With Best Possible RX	20/	20/	20/

- |   |     |    |
|---|-----|----|
| 1. For best possible distance visual acuity have corrective lenses been prescribed? | Yes | No |
| 2. Have the corrective lenses been dispensed?                                       | Yes | No |
| 3. Is there any difficulty seeing in dim light or at night?                         | Yes | No |

**Recommended restrictions (check all that apply below):**

Corrective Lenses _____	Left Outside Rearview Mirror _____
50 Mile Radius of Residence _____	No Driving Outside City Limits _____
Daylight Only _____	Other _____

**Doctor's opinion regarding applicant's visual ability to drive safely:**

Does patient have any other visual deficiency which, to your knowledge, would prevent him/her from safely operating a motor vehicle? (INADEQUATE VISION)    Yes                  No                  If yes, please explain \_\_\_\_\_

Being a licensed optometrist or ophthalmologist, I certify that I have personally examined the eyes of the applicant named and a true record of this examination appears above. **Doctor must complete all info below.**

Doctor's Name (Please Print Legibly) \_\_\_\_\_

Doctor's Address (Please Print Legibly) \_\_\_\_\_

Doctor's Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Date of Exam (Vision Statements are honored for 6 months from the exam)** \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Return completed application to: Department of Public Safety, Driver Licensing Office, 118 W. Capitol Avenue, Pierre SD 57501. May be faxed to (605) 773-3018 or emailed to [DPSLicensingInfo@state.sd.us](mailto:DPSLicensingInfo@state.sd.us).