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:	Both Eyes Together	Right Eye	Left Eye
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 1 year 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 DPSDL@state.sd.us