

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

**VISION STATEMENT**

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

Address \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

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 and dispensed? \_\_\_\_\_
2. Is there any difficulty seeing in dim light or at night? \_\_\_\_\_
3. Recommendation as to frequency of visual re-examination: 1 YR \_\_\_\_\_ 2 YR \_\_\_\_\_ 3 YR \_\_\_\_\_
4. Doctor's opinion regarding applicant's visual ability to drive safely:
  - a. Without restrictions \_\_\_\_\_
  - b. With restrictions \_\_\_\_\_
  - c. Inadequate \_\_\_\_\_

**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 \_\_\_\_\_

Does patient have any other visual deficiency which, to your knowledge, would prevent him/her from safely operating a motor vehicle? 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's Name (Please Print Legibly) \_\_\_\_\_

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

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

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

Return completed application to: Department of Public Safety, Driver Licensing Office, 118 W. Capitol Avenue, Pierre SD 57501 or fax to (605) 773-3018.