

**North Carolina Department of Motor Vehicles Vision Specialist
Form DL77**

I, _____, hereby authorize Dr. _____ to provide my examination information for the purposes of determining my visual fitness to operate a motor vehicle. I understand this authorizes the Division to review my case.

Applicant Signature _____ License/Customer number _____

Parent/Guardian if Minor _____ Telephone number _____

To be completed by licensed Ophthalmologist or Optometrist

1. What is the vision diagnosis? _____

2. Which eye(s) are affected: both right left

3. Is the condition: permanent stable progressive improving

(check all that apply)

4. Best corrected Visual Acuity:
(Using conventional lenses)

Both 20/	Right 20/	Left 20/
Both 20/	Right 20/	Left 20/

5. Uncorrected Visual Acuity:

6. New lenses prescribed? Yes No

7. Are corrective lenses recommended for driving? Yes No

8. What is the horizontal field of view in each eye without field expanders? (**Specify in degrees**)

Right Eye: _____° nasal _____° temporal	Left Eye: _____° nasal _____° temporal
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Test used: Confrontation Goldmann Automated

9. Are there other visual issues that might affect driving?

No Depth perception Diplopia Contrast sensitivity Glare sensitivity Color vision impairment

10. Is a bioptic telescope used for driving? Yes No (**If no, skip to # 16**)

11. If yes, how long has the bioptic been used? New Duration: _____ months/years (circle)

12. If yes, for which eyes(s)? Both Right Left

13. Visual acuity through bioptic telescope: Both: 20/_____ Right: 20/_____ Left: 20/_____

14. Has the individual driven previously without a bioptic telescope? Yes No

15. Has the individual completed certified training in the use of a bioptic for driving? Yes No

16. Are there any other concerns regarding this individual's fitness to safely operate a motor vehicle?

No Cognitive Physical Psychological Other: _____

17. What driving restriction(s), if any, do you recommend based upon your examination?

None 45mph limit/No interstate Daylight only Local driving only: _____ miles from home **Should not drive**

18. Other recommendations for highway safety purposes (check all that apply):

DMV follow-up: 6 months every: circle: (1) (2) (3) year(s)

On road evaluation by DMV (or approved examiner)

Other: _____

Vision Examiner:

Name _____ Degree _____ License # _____

Address _____

Phone _____ Fax _____

Signature _____ Date _____

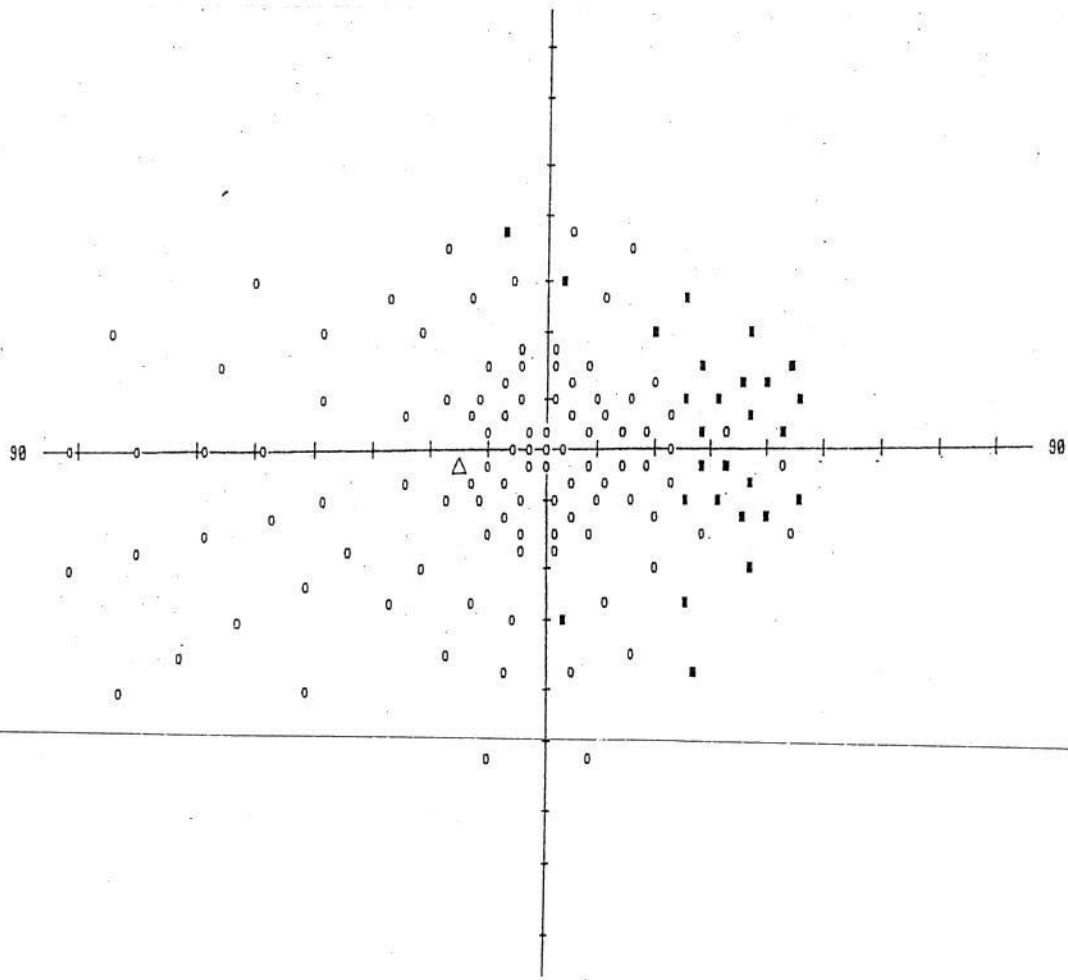
Instructions: Fax this completed and signed form to the NC DMV Medical Review Section at (919) 733-9569

**North Carolina Division of Motor Vehicles
Commercial Drivers License Waiver Program**

Vehicle and Driving Conditions Report

Status of the driver	Applied/accepted to truck driving school	Currently enrolled student in truck driving school								
	Unemployed	Hired pending exemption	Currently employed							
Employer _____ Address _____ City _____ State _____ Zip Code _____ Area Code and Number _____										
Name of the Driver _____ Date of Birth _____ License Number _____										
FORM COMPLETED BY										
Printed Name _____		Signature _____	Date Completed _____							
If the driver operates more than one type of vehicle, check all that apply.										
TRUCK	Gross Vehicular Weight		Drive Train Information	Number of axles						
				Number of manual forward speeds						
				Number of auxiliary forward speeds						
				Number of rear axle transmission forward speeds						
				Transmission type: Manual	Automatic					
				Braking	Manual	Powered	Airbrakes			
	Steering	Manual	Powered							
For passenger vehicles, seating capacity:										
TRAILER(S)	Gross Vehicular Weight		Number towed at one time	1	2	3	Van		Flatbed	
							Bin		Tanker	
							Pole		Other	
MODIFICATIONS MADE FOR THE DRIVER (if applicable)		(include relevant photographs)								
TIME AND DISTANCE			Round trip distance	Hours per 7 day week	Hours per 24 hour day	Daylight hours per week	Nighttime hours per week			
		Average								
		Maximum								
TRAFFIC AND ROAD CONDITIONS			Secondary roads			Rural				
			Interstate highway			Urban				
TRANSPORTED CARGO		List _____								
NON-DRIVING ACTIVITIES		Hitching and unhitching			Loading and unloading					
		Covering or tying down			Filling or emptying tankers					
		Other (describe) _____								
TYPE OF DRIVER OPERATION		Relay								
		Single driver								
		Sleeper team								
		Owner-operator								
		Non-driving individuals accompanying the driver								
Number of years of driving experience:		Total years driving experience								
		Number driving the vehicle described above								

THIS IS A SAMPLE COPY



- SEEN 108/135
- NOT SEEN 27/135
- △ BLINDSPOT

CDL WAIVER COVER SHEET

ATTENTION: THIS PAGE MUST BE COMPLETED AND INCLUDED WITH ANY WAIVER DOCUMENTS THAT ARE SUBMITTED

NAME _____

DATE OF BIRTH _____

DRIVERS LICENSE NO. _____

CIRCLE TYPE OF WAIVER: **DIABETIC** **VISION** **LIMB**

MAIL OR FAX INFORMATION:

MEDICAL REVIEW UNIT
3112 MAIL SERVICE CENTER
RALEIGH, NC 27697
FAX NO: (919) 733-9569

IMPORTANT!!!

PLEASE INCLUDE THIS PAGE WITH YOUR COMPLETED FORMS WHEN FAXING OR MAILING WAIVER DOCUMENTATION TO DMV.