Division of Vehicles
Driver Solutions/Medical & Vision Unit
PO Box 2188
Topeka KS 66601-2188

Kansas
Department of Revenue

Telephone: (785) 368-8971
FAX: (785) 296-5857
www.ksrevenue.org

VISION FORM INSTRUCTIONS

To the Driver:

- Make sure your full name and date of birth are legible.
- If your address has changed, please provide your full, current address (including city, state and ZIP code) to have it updated in our system.
- The vision form must be signed by the driver in order to be processed.

To the optometrist/ophthalmologist:

- If the driver needs corrective lenses for driving, the "Present Lenses" and "Best Correction" fields must be completed. If corrective lenses are not required, the "Without Lenses" field must be completed.
- Please use numerical values for acuities and horizontal field of vision when possible.
- The "safety" question in bold must be answered if the driver does not see better than 20/60 in at least one eye or have a total angle greater than 110 degrees. If you are unsure, request a drive test.
- The restrictions listed are the only restrictions available to place on a driver's license.
- Restriction(s) cannot be removed by leaving the boxes unchecked. If you believe a restriction should be removed from a driver's license, please state on the form which restriction(s) can be removed at this time.

PLEASE RETURN COMPLETED VISION FORM TO:

PH: (785) 368-8971
FAX: (785) 296-5857

STATE OF KANSAS DIRECTOR OF VEHICLES
MEDICAL/VISION UNIT
915 HARRISON STREET
PO BOX 2188
TOPEKA KS 66601-2188

KANSAS DIVISION OF VEHICLES VISION FORM

Name of Applicant: _____ DL#: _____

Applicant Address: _____ DOB: _____

Are you enrolled in Driver's Education? YES ☐ NO ☐

Instructor's Name: _____ Instructor's Phone #: _____

Applicant: Your signature is your release for eye doctor to give your vision information_____

IF RENEWING: YOU MAY RECEIVE YOUR VISION TEST FREE OF CHARGE AT THE DRIVER LICENSE EXAMINING STATION. If you fail to test 20/40 in at least one eye at the examining station, you will be required to take THIS FORM to a vision specialist. If you fail to test 20/60 in at least one eye by the vision specialist, your report may be forwarded, by the Examiner, to the DIVISION OF VEHICLES. An examination administered within the past 90 days is required.

FOR ANNUAL REVIEWS: Please have this form completed by your eye specialist. Return completed form, within sixty (60) days, to the DIRECTOR OF VEHICLES for review and recommendations regarding your driving privileges. Recent exam required (Within past ninety (90) days). Please fax completed exam to (785) 296-5857 or mail to Medical / Vision Unit PO Box 2188 Topeka, Ks. 66601-2188. Processing time is 7 – 10 business days.

INSTRUCTIONS FOR LICENSED OPTOMETRIST/OPHTHALMOLOGIST

Please sign this report after completing the questions on the form below. No recommendations or suggestions as to which specialists to visit are given by the Driver License Examiners. The eye specialist assumes no liability in making this report. See Kansas Statute Section 8-247 (d) (6).

VISION FORM TO BE COMPLETED BY OPTOMETRIST OR OPHTHALMOLOGIST

	Acuity Right Eye	Left Eye	Both Eyes	Horizontal Field of Vision
Present Lenses:	20/____	20/____	20/____	Right of Fixation: _____
Without Lenses:	20/____	20/____	20/____	Left of Fixation: _____
Best Correction:	20/____	20/____	20/____	Total Angle: _____
Bioptic/Telescopic: **(If prescribed for driving)**	20/____	20/____	20/____	

Driver wears contact lenses or glasses for correcting vision. YES☐ NO☐

Driver must take and pass a drive test at a Kansas Exam Station. YES☐ NO☐

Diagnosis of visual condition: _____

In my professional opinion, I believe this person can safely operate a motor vehicle at this time in regards to their current vision reading. (Driver must be considered a safe candidate in order to request a drive test.) YES ☐ NO ☐

(This question may be omitted if visual acuity is better than 20/60 in at least one eye and visual angle is greater than 110°. Applicant must also meet all other qualifications required for issuance of a driver's license as determined by the Driver's License Examiner or the Director of Vehicles.)

An Annual Vision Report should be required: YES ☐ NO ☐

Applicant's physical / medical condition should be evaluated: YES ☐ NO ☐

Recommendations / Restrictions to be placed on the license if issued:

☐Corrective Lenses
☐Daylight Hours Only
☐No Interstate / Freeway Driving
☐Outside Business Area
☐ Within City Limits
☐ Licensed Driver in Front Seat
☐ Mechanical Aid
☐ Prosthetic Aid

(Limit 6)
☐ Outside Mirror
☐ Automatic Transmission
☐ (___)Miles from Home
(5-30 in 5 mile increments)

_____ _____

Name of Optometrist / Ophthalmologist (Please print) Date of Examination (Within the last 90 days)

_____

Address

_____ _____

Signature of Optometrist / Ophthalmologist

Phone:_____ Date Signed: _____