TENNESSEE DEPARTMENT OF SAFETY
DIVISION OF DRIVER LICENSING AND CONTROL
CERTIFICATE FOR BIOPTIC LENS APPLICANT

NAME (FIRST) (MIDDLE) (LAST)	D.O.B	DRIVER LICENSE /ID NUMBER

LEGAL ADDRESS	P.O. BOX	CITY	STATE	ZIP

MOBILITY

Is there any condition existing relative to the skeletal, muscular and/or cervical spine system(s) which could prevent normal movement of the head or eyes? YES_____ NO_____

If Yes Please describe _____

Bioptic System	System Type	Dispense Date Mo. / Day / Yr.	Power	Monocular	Binocular	RE	LE
				☐ Yes ☐ No	☐ Yes ☐ NO		

VISUAL INFORMATION

Cond. Diagnose Date Mo. / Day / Yr.	Description of Condition

Stability Of Condition	Remarks
Progressive ☐ Stable ☐ Undetermined ☐	

Visual Acuity /Fields	With Non-telescopic Corrective Lens RE	LE	* NA	With Telescopic And Corrective Lens RE	LE	Degree(s) of Loss if any, Or Central Field of vision RE	LE	Horizontal Visual Field Diameter (Without Bioptic and/or it's lens) RE	LE
	20/	20/		20/	20/	20/	20/	20/	20/

* NA- Means no corrective lens needed

I certify that the above patient has taken and passed the approved vision rehabilitation program. Yes_____ No_____

I also certify that the above has passed an approved Drivers Education Program. Yes_____ No_____

Signature of Doctor	Medical License #	Address	Date

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