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

NAME (FIRST) (MIDDLE) (LAST)	D.O.B	SOCIAL SECURITY 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

SF-0991