Tennessee Department of Safety and Homeland Security

Certificate for Bioptic Lens Use

DRIVER INFORMATION

NAME _____
First Middle Last

DOB _____ DRIVERS LICENSE / ID NUMBER _____
MO - DAY - YEAR

ADDRESS _____
Street City State Zip

MOBILITY

Is there any condition existing relative to the skeletal, muscular, or cervical spine (systems) which could prevent normal movements of the head or eyes? Yes | No

If yes, please describe:

BIOPTIC SYSTEM

System Type:	Date dispensed:	Power:	Binocular:		RE	LE
			Yes	No		

VISUAL INFORMATION

Description of Condition:

Date diagnosed:	Stability of Condition: check one	Progressive	Stable	Unknown

VISUAL ACUITY / FIELDS

With non-telescopic corrective lens:		With telescopic and corrective lens:		Degrees of loss of central field of vision:	
RE	LE	RE	LE	RE	LE
20/	20/	20/	20/		

Total visual horizontal field diameter using both eyes:

CERTIFICATION

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

Yes No

I also certify that the above patient has passed an approved driver education program.

Yes No

Signature of Doctor Medical License # Address Date