Form MCSA-5871

OMB Control Number: 2126-0006
Expiration Date:

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

VISION EVALUATION REPORT

Name: _____ DOB: _____

Driver's License Number (if applicable): _____ State: _____

Information for the Individual:

The certified medical examiner must receive this report and begin the physical qualification examination no later than **45** calendar days after an ophthalmologist or optometrist signs this report.

Information for the Ophthalmologist or Optometrist:

This individual is being evaluated as part of the process to determine whether the individual meets the vision standard of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle in interstate commerce. This report is required to provide information for an individual who has "monocular vision," as defined by FMCSA, or did not meet FMCSA's vision standard at a physical qualification examination. An ophthalmologist or optometrist should complete this report to the best of the ophthalmologist's or optometrist's ability based on the evaluation of the individual and knowledge of the individual's medical history. The determination as to whether the individual meets the vision standard and is physically qualified to drive a commercial motor vehicle will be made by a certified medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines monocular vision as:

> *(1) in the better eye, distant visual acuity of at least 20/40 (with or without corrective lenses) and field of vision of at least 70 degrees in the horizontal meridian, and*
> *(2) in the worse eye, either distant visual acuity of less than 20/40 with corrective lenses or field of vision of less than 70 degrees in the horizontal meridian, or both.*

For general informational purposes only, to meet FMCSA's monocular vision standard, an individual must:

(1) have in the better eye distant visual acuity of at least 20/40 (Snellen), with or without corrective lenses, and field of vision of at least 70 degrees in the horizontal meridian;
(2) be able to recognize the colors of traffic signals and devices showing standard red, green, and amber;
(3) have a stable vision deficiency; and
(4) have had sufficient time since the vision deficiency became stable to adapt to and compensate for the change in vision.

Name: _____DOB: _____

PLEASE CHECK / FILL IN REQUESTED INFORMATION (PLEASE PRINT)

1. I am an ophthalmologist ☐ I am an optometrist ☐
2. Date of vision evaluation: _____ (MM/DD/YYYY)
3. Distant visual acuity (**please provide both if applicable**):

   Uncorrected: right eye: 20/_____ left eye: 20/_____

   Corrected: right eye: 20/_____ left eye: 20/_____

   Type of correction: glasses ☐ contacts ☐
4. Field of vision, including central and peripheral fields, utilizing a testing modality that tests to at least 120 degrees in the horizontal. Formal perimetry is required. **Attach a copy of the formal perimetry test for each eye and interpret the results in degrees of field of vision.**

   Right eye: _____degrees ("normal" or "full" are not acceptable)

   Left eye: _____degrees ("normal" or "full" are not acceptable)

   Test used to determine results: _____
5. Is the individual able to recognize the standard red, green, and amber traffic control signal colors? YES ☐ NO ☐
6. Date of last comprehensive eye examination: _____ (MM/DD/YYYY) or unknown ☐
7. Does the individual have monocular vision as it is defined by FMCSA? YES ☐ NO ☐

   If yes, cause of the monocular vision (describe): _____

   _____

   _____
8. Date the monocular vision began: _____(MM/YYYY)
9. Current treatment: _____ or N/A ☐

Name: _____DOB: _____

10. Does the individual have any progressive eye condition or disease (e.g., macular edema, cataracts, glaucoma, or retinopathy)? YES ☐ NO ☐

    If yes, provide the condition or disease, date of diagnosis, severity (mild, moderate, or severe), current treatment, and whether the condition is stable. Please enter the information in the table below.

Condition or Disease	Date of Diagnosis	Severity			Current Treatment	Is Condition Stable?	
		Mild	Moderate	Severe		Yes	No
a)		☐	☐	☐		☐	☐
b)		☐	☐	☐		☐	☐
c)		☐	☐	☐		☐	☐

11. In your medical opinion, is the individual's vision deficiency stable? YES ☐ NO ☐

    If yes, date the vision deficiency became stable: _____(MM/YYYY)

12. In your medical opinion, has sufficient time passed since the vision deficiency became stable to allow the individual to adapt to and compensate for the change in vision and to drive a commercial motor vehicle safely? YES ☐ NO ☐

13. In your medical opinion, is a vision evaluation required more often than annually? YES ☐ NO ☐

    If yes, how often and why? _____

Name: _____DOB: _____

14. Additional comments (attach additional pages as needed): _____

_____

_____

_____

_____

I attest that I am an ophthalmologist or optometrist and that the information provided is true and correct to the best of my knowledge.

_____
Date

_____ _____
Printed Name and Medical Credential Signature

_____
Professional License Number and State

_____ _____
Phone Number Email

_____ _____
Street Address City, State, Zip Code