



Eye Examination Certificate
(NAC 483.310, 483.340)

Name of Applicant (LAST Name) (First Name) (Middle Name)

Applicant's Date of Birth (MM/DD/YYYY) Nevada Driver's License No.

Applicant's Address

Applicant's Phone Number

I, (Printed Name of Physician or Optometrist Licensed to Practice in Nevada), certify that I have examined the above-named applicant and offer the following record of the eye examination.

Table with 3 columns: Without Rx, With Current Rx, With New Rx If Being Changed. Rows for Right Eye, Left Eye, and Both Eyes.

Could visual acuity deficiency be corrected with glasses? Yes No

Are glasses being fitted? ...Yes No Are there any progressive abnormalities? ...Yes* No

Will the applicant's condition (as described above) impair his/her ability to safely operate a motor vehicle? .Yes* No

*If Yes, please further explain the case and recommend restrictions:

Blank lines for physician's explanation of restrictions.

Physician's Signature Duly licensed to practice in Nevada.

Physician's Office Street Address

Date of Examination

City, State, and Zip Code

Physician's Office Telephone Number

Applicant's Signature

PLEASE NOTE: This Eye Examination Certificate must be presented within 90 days of the date the examination was performed by a physician or optometrist licensed to practice in the State of Nevada.