



EYE EXAMINATION CERTIFICATE NAC 483.310 & 340

Name of Applicant _____
Last First Middle

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

Applicant's Address _____

Applicant's Phone Number _____

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

	Without RX	With Current RX	With New RX If Being Changed
Right Eye	20/ _____	20/ _____	20/ _____
Left Eye	20/ _____	20/ _____	20/ _____
Both Eyes	20/ _____	20/ _____	20/ _____

Could visual acuity deficiency be corrected with glasses? Yes ☐ No ☐

Are glasses being fitted? Yes ☐ No ☐ Are there 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: _____

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.