DMV.NV.GOV

Driver's License Review
555 Wright Way
Carson City, NV 89711
Reno/Carson City – (775) 684-4DMV (684-4368)
Las Vegas – (702) 486-4DMV (684-4368)
dmv.nv.gov

Eye Examination Certificate

(NAC 483.310, 483.340)

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

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 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: _____

_____

_____

_____

_____ Duly licensed to practice _____ in Nevada.
Physician's Signature

_____ _____
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.

DP18 (Revised 12/2007; replaced form DLD18.)