MATURE DRIVER VISION TEST

(This form is not valid after one year from date of examination.)

I hereby authorize (PRINT DOCTOR'S FULL NAME) to give me this vision examination and to submit this report to the Division of Motorist Services.				
Patient's Signature	Driver License Number			
Patient's Address, Street, and Number	City/State-Zip			
463, FLORIDA STATUTES, OR A LICEN	RIZED TO PRACTICE UNDER CHAPTER 458, 459 OR SED PHYSICIAN AT A FEDERALLY ESTABLISHED THAT I HAVE PERSONALLY EXAMINED THE EYES			
Patient's Name	Date of Birth			
AND THAT A TRUE RECORD OF THIS I AND THAT SAID PATIENT SIGNED AB	EXAMINATION APPEARS ON THE FORM BELOW, OVE IN MY PRESENCE.			
Physician's License #	Signature of Physician			
Date of Exam	Business Address			
	Telephone			

NOTE: The Report of Eye Exam (HSMV 72010) must be used if: 1) the patient's visual acuity is 20/50 or worse in either eye, OR 2) there is any indication of eye disease or injury that would affect patient's driving ability.

DISTANT VISION ONLY	RIGHT EYE	LEFT EYE	BOTH EYES
VISION UNCORRECTED	20/	20/	20/
VISION WITH BEST CORRECTION	20/	20/	20/

FLORIDA MINIMUM VISUAL STANDARDS FOR LICENSING

20/50 or worse in either eye with or without corrective lenses are referred to an eye specialist for possible improvement.

130 degrees is the minimum acceptable field of vision.

The use of telescopic lenses to meet visual standards is not recognized in Florida.

HSMV 72119 S (Rev 02/18)