ADOT
Motor Vehicle Division

Mail Drop 818Z
Medical Review Program
PO Box 2100
Phoenix AZ 85001-2100

96-1509 R10/14 azdot.gov

VISION ANNUAL EVALUATION ARIZONA INTRASTATE DIABETES WAIVER PROGRAM CHECKLIST

Clear

Driver Identifying Information

Name:(first, mi, last)
Address: (city, state, zip code)
DOB (mm/dd/yyyy)

This Individual was granted an Arizona Intrastate diabetes waiver from the Arizona Department of Transportation (ADOT) diabetes standard to operate a commercial motor vehicle (CMV) in intrastate commerce. Annual medical monitoring and reporting is a condition of the waiver from the diabetes standard of Arizona Administrative Code (AAC) R17-5-208 and 49 CFR 391.41(b) (3). An applicant with diabetic retinopathy must be evaluated by an ophthalmologist. The vision examination must occur AFTER any eye surgery/ procedures (postoperatively):

PLEASE CHECK/FILL IN REQUESTED INFORMATION

1. ❑ I am an ophthalmologist ❑ I am an optometrist

2. Date of most recent examination: (mm/dd/yyyy)_____

3. Distant Visual Acuity **(please provide both if applicable)**

❑ UNCORRECTED

Right eye: 20/ _____
Left eye: 20/ _____

❑ CORRECTED
❑ Glasses ❑ Contact Lens

Right eye: 20/ _____
Left eye: 20/ _____

4. Field of vision (FOV)*:
Please record the interpreted results in **degrees** of horizontal field of vision for each eye. The terms “normal” or “full” are not acceptable responses.

Right eye: _____degrees
Left eye: _____degrees
Test used to determine:_____

*__Note:__ If the patient has received laser treatment, and in your medical opinion you believe the patient's FOV is compromised, Arizona medical Review Program (AZMRP) recommends formal perimetry to determine if the driver meets the FOV standard.

5. Does the patient have diabetic retinopathy? ❑ YES ❑ NO

If yes: ❑ Proliferative
❑ Stable ❑ Unstable
❑ Non-proliferative
❑ Stable ❑ Unstable

Treatment:_____

Date diagnosed:_____

Surgery/procedures:_____

Requires recheck in _____months
6. Does the patient have macular edema?
❑ YES ❑ NO

Requires recheck in _____months
7. Does the patient have cataract(s)?
❑ YES ❑ NO

Requires recheck in _____months
8. Does the patient have any other medical diagnosis related to vision?
❑ YES ❑ NO

If yes, what?_____
❑ Stable ❑ Unstable

Requires recheck in _____months

Printed name	Signature
License Number	Today's date
Date of Expiration	State of Issue

Please send this completed annual vision checklist to:

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If you have questions or need additional information, please call 602-771-2460