DR 2402 (03/14/24)
COLORADO DEPARTMENT OF REVENUE
Division of Motor Vehicles
P.O. Box 173350
Denver CO 80217-3350
FAX: (303) 205-8301

Confidential Eye Examination Report

Instruction Sheet

The Driver/Patient Section is to be completed by the Driver/Patient.

1. The Driver/Patient should fill in their Name, Address, Customer Identification Number, if known, and Date Of Birth.
2. The Driver/Patient should sign this section.

The Physician/Ophthalmologist section is to be completed by a Physician (MD or DO), Physicians Assistant (PA) or an Ophthalmologist/Optometrist (OD).

1. The form is valid for 180 days from the date of the examination.
2. If the 'Require DMV retesting in one year?' question is not answered, "No" will be assumed and selected as a default answer.
3. The Physician/Ophthalmologist observation section required fields must be completed.
4. Only **one** of the fitness to operate options must be selected.
5. Any alterations, erasures or multiple selections of the fitness to operate options will result in an invalid and rejected form.
6. The form must be signed by a Physician (MD or DO), Physicians Assistant (PA) or an Ophthalmologist/Optometrist (OD).
7. **Forms signed by a Nurse Practitioner (NP) will be rejected.**

If a DR 2402 is requested by the Department of Motor Vehicles, Drivers License Office, the examination date on the form needs to be after the issue date of the notice of cancellation and denial. The form is valid for 180 days from the date of the examination.

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Driver/Patient Section

Patient Last Name | First Name | Middle Initial

Street Address

City | State | ZIP Code

Customer Identification Number (CIN) | Date of Birth

Driver Statement of Understanding (Driver signature not required for DMV processing):

- My Physician/Ophthalmologist/Optometrist will conduct an eye examination to determine my fitness to operate a motor vehicle safely and responsibly.
- My Ophthalmologist/Optometrist will respond to any additional questions from the Department of Motor Vehicles (DMV).
- I understand that this form will be considered in any decision regarding the issuance of my driver license, pursuant to C.R.S. 42-2-111 & 42-2-112.

Signature of Driver or Patient | Date (MM/DD/YY)

Ophthalmologist/Optometrist/Physician Section

Instructions: use your best clinical judgment as you **review and complete all sections.** Base severity ratings within each category on your overall assessment of impairment relative to the driving task. Form must be completed by the Physician (MD or DO) or OD. Pursuant to C.R.S. 42-2-112, no civil or criminal actions shall be brought against any physician, physician's assistant, or optometrist based in Colorado for providing a medical opinion if the physician, physician's assistant, or optometrist acts in good faith and without malice.

Colorado Vision Recommendations – 20/40 or better in either eye with or without corrective lenses, and total combined horizontal field of vision, with both eyes, of at least 120 degrees, or if blind in one eye, at least 60 degrees in the other eye. If best visual acuity with or without corrective lenses is worse than 20/100 in the carrier lenses, the bioptic telescope must correct the visual acuity to at least 20/40.

Examination Information (check all that apply and please do not abbreviate)

Applicant is currently being treated for one or more of the following progressive ocular condition(s):

☐ Macular Degeneration ☐ Retinitis Pigmentosa ☐ Glaucoma ☐ Visual Field Deficit ☐ N/A

☐ Other

Does patient have visual field deficit which makes driving unsafe?..... ◯ Yes ◯ No

Additional Information

Distance Acuity **With Correction:**						Distance Acuity **Without Correction:**						Distance Acuity **Bioptic Lens:**					
Right		Left		Both		Right		Left		Both		Right		Left		Both	
20/		20/		20/		20/		20/		20/		20/		20/		20/	

Horizontal Perception Fields

Left: ◯ Pass ◯ Deficient ◯ Fail

Right: ◯ Pass ◯ Deficient ◯ Fail

Require DMV retesting in one year?..... ◯ Yes ◯ No

Examination Date (MM/DD/YY)

(Form is valid for 180 days from date of exam)

Patient Last Name | First Name | Middle Initial

Based on my observations of this patient and information relayed to me by this individual, I, reasonably and in good faith, believe that:

Patient Name

is

Must Choose One:

◯ Fit to operate a motor vehicle safely.

◯ Fit to operate a motor vehicle safely contingent upon passing a DMV Road Test.

◯ **Not Fit** to operate a motor vehicle safely and responsibly due to significant medical-functional compromise or deficit.

◯ Fitness to drive determination pending; rehab permit required

Recommended license restriction(s):

☐ Daylight Driving Only

☐ No Highway/Freeway Driving

☐ Automatic Transmission Only

☐ Mile Radius Only

☐ Bioptic Lens

☐ Restricted MPH

☐ Other

☐ Patient also requires a medical exam

Specialty (Required) | License Number (Required) | Phone Number (Required)

Street Address

City | State | ZIP Code

Physician Name (Printed)

Signature (Required) | Date (MM/DD/YY)