



**Minnesota Department of Transportation**

**Office of Freight and Commercial Vehicle Operations**

Mail Stop 420  
395 John Ireland Boulevard  
St. Paul, MN 55155-1899

Phone: 651/215-6330

Fax: 651/366-3718

**Insulin-dependent Diabetic Driver Waiver  
Eye Examination Report**

Dear Eye Care Professional:

(Patient's name) \_\_\_\_\_ who appears before you is applying to this office for a waiver from the medical standards for commercial vehicle drivers. We must have information as to whether the patient's diabetic condition has had an effect on his/her visual health. Please examine the patient according to the criteria listed below, and answer each question accordingly. Finally, please sign and date the report.

Does this patient have unstable proliferative diabetic retinopathy?    yes    no

What is this patient's distant visual acuity (Snellen)?    Left: 20/\_\_\_\_    Right: 20/\_\_\_\_

Is this reading with or without corrective lenses?    with    without

Does the patient's visual acuity appear to be stable?    yes    no

\_\_\_\_\_  
Ophthalmologist or Optometrist name and title  
(please print)

\_\_\_\_\_  
Minnesota license number

\_\_\_\_\_  
Office/clinic name and telephone number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date of examination