Reset Form

VISION SCREENING DOCUMENTATION

State Form 56520 (R4 / 8-24)
INDIANA BUREAU OF MOTOR VEHICLES

The legal authority for this form is IC 9-24-10.

INSTRUCTIONS:

1. *Complete this form entirely in black or blue ink.*
2. *Please read each section thoroughly.*
3. *Section A is to be completed by the applicant. Section B is to be completed by the applicant's Ophthalmologist or Optometrist.*
4. *As this form is a substitute for the vision screening that would occur in the license branch, a credential applicant must provide this form to a licensed Ophthalmologist or Optometrist. The Ophthalmologist or Optometrist must complete section B as well as the signature and date section. A completed vision screening form will be valid for one (1) year from the date of the exam.*
5. *This form may not be used if a customer has below 20/50 vision in either eye or is currently under a Driver Ability review. In this case, the customer must complete State Form 22106, Certificate of Vision (Eye Referral).*
6. *Applicants must submit the completed form at a local license branch during a renewal, amendment or new issuance transaction. A completed vision screening form will be valid for one (1) year from the date of the exam.*
7. *Applicants **over** the age of seventy-five (75) wishing to renew their Indiana credential online, submit the form by mail to: Indiana Bureau of Motor Vehicles, Attention: Driver Ability Department, 100 N Senate Ave Room N481, Indianapolis, IN 46204. The vision screening form will be valid for thirty (30) days from the date of the exam for an online renewal.*

SECTION A: Customer Information	
Name *(last, first, middle)*	Customer date of birth *(mm/dd/yyyy)*
Customer driver's license or identification card number	
By Signing I authorize this information to be released to the Indiana Bureau of Motor Vehicles.	
Signature of credential applicant	Date of application *(mm/dd/yyyy)*

SECTION B: Ophthalmologist or Optometrist Information		
Is the customer required to wear glasses? ☐ Yes ☐ No		
Is the customer required to wear contacts? ☐ Left Eye ☐ Right Eye ☐ Both Eyes		
Vision Acuity Reading		
Left Eye	**Right Eye**	**Both Eyes**
20 /	**20 /**	**20 /**
I have personally examined the listed named driver for visual conditions which might have direct bearing upon his or her qualifications to meet Indiana vision standards for driving.		

Ophthalmologist or Optometrist Signature			
Date of Examination *(mm/dd/yyyy)*	Ophthalmologist or Optometrist license number		
Signature of Doctor	Typed or Printed Name of Doctor		
Address *(number and street)*	City	State	ZIP Code