NEBRASKA State Patrol - Concealed Carry Weapon (CCW) Form

STATEMENT OF VISION

Once completed, please email, mail or fax to: 3800 NW 12th Lincoln, NE 68521

Email: nsp.ccw@nebraska.gov
FAX: 402-479-4321

NOT VALID AFTER 90 DAYSFROM EXAMINATION DATE

(Applicant completes before doctor's exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my visual condition and history to the Department of Motor Vehicles, State of Nebraska.

Dated: _____ Signed: _____
(Applicant's Signature)

I hereby certify that I examined the eyes of _____
(Applicant's Name)

of _____
(Street Address) *(City)* *(Zip Code)*

Date of Birth _____ License Number _____

To be completed by optometrist or ophthalmologist. (REQUIRED)

1. Unaided acuity: Both _____ Left Eye _____ Right Eye_____

2. a. Best correctable acuity: Both _____ Left Eye _____Right Eye _____

   b. Visual acuity using telescopic lens: 20/_____ (Both) 20/_____ (Left) 20/_____ (Right)

   c. Visual acuity through carrier lens: 20/_____ (Both) 20/_____ (Left) 20/_____ (Right)

   d. Type of lenses used: Std. Spectacle _____ Aphakic _____
   Contact Lenses _____ Telescopic Lenses _____

3. Extent of entire horizontal form field, either binocular or monocular, as determined with a III4e or V4e Goldmann test target or equivalent, such as the SSA Kinetic V4e isopter test on Humphrey Field Analyzers.

   Left Eye: _____ Degrees Temporal Right Eye: _____ Degrees Temporal
   _____ Degrees Nasal _____ Degrees Nasal

   Field of Vision looking through carrier lens: _____° Temp (Left) _____° Temp (Right)
   _____° Nasal (Left) _____° Nasal (Right)

To be completed by optometrist or ophthalmologist. (REQUIRED)

4. Are new corrective lenses required? Yes _____ No _____

5. Diplopia: *(Check appropriate line.)*

   _____ a. highly unlikely to occur

   _____ b. intermittent* *Please Explain:_____

   _____ c. constant* _____

6. If best visual acuity is less than 20/40 in either eye or both, or total horizontal form field is less than 140 degrees, give cause and probable prognosis under Additional Comments.

Answer questions #7 and #8 only for commercial motor vehicle operators.

7. Based upon your examination, has the vision condition of this patient, which was in existence prior to July 30, 1996, significantly worsened or another condition developed? ☐ No ☐ Yes

   If yes, please explain: _____

   _____

8. Color blindness: Able to recognize the colors of traffic signals and devices showing standard red, green and amber. ☐ No ☐ Yes

9. Do you feel that this patient should have a follow up vision examination (which will require the completion/submission of a DMV Statement of Vision to the DMV) for the purpose of operating a motor vehicle safely? ☐ No ☐ Yes
   If yes, how often? _____

10. **Date of eye examination:** _____
    (MUST BE COMPLETED—STATEMENT OF VISION NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE.)

Additional Comments: _____

_____

_____

_____

_____ _____

Name of Optometrist or Ophthalmologist (Please Print) | Signature of Optometrist or Ophthalmologist*

_____

Address of Optometrist or Ophthalmologist (Please Print)

Telephone Number of Optometrist or Ophthalmologist: (____) _____

Fax Number of Optometrist or Opthalmologist: (___) _____

* **If the applicant needs new corrective lenses to get the best correctable acuities listed on page 1, please delay signing this statement until the new lenses are in use by the applicant.**