NEBRASKA STATE PATROL
Concealed Handgun Permit – Statement of Vision

1. Applicant Information
   To be completed prior to doctor’s examination

   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 Nebraska State Patrol.

   Dated: _______________________ Signed: ______________________________________________
   (Applicant’s Signature)

   Applicant Address: ___________________________________________________________________________________________________
   (Street Address)                                                                                            (City)                                          (State)                                         (Zip Code)

2. Examination Report
   To be completed by optometrist or ophthalmologist

   1. Unaided acuity: Both ________ Left Eye ________ Right Eye ________

   2. a. Best correctable acuity: Both ________ Left Eye ________ Right Eye ________

      b. Visual acuity using telescopic lens: Both __20/_____ Left Eye __20/____ Right Eye __20/_____ 

      c. Visual acuity through carrier lens: Both __20/____ Left Eye __20/____ Right Eye __20/____

      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

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

   4. Are new corrective lenses required?  _____Yes  _____No

   5. Diplopia: (Check appropriate line.)
      _____ a. highly unlikely to occur
      _____ b. intermittent*
      _____ c. constant*

      *Please explain: ______________________________________________________________________________________________
      ____________________________________________________________________________________________________________
      ______________________________________________________________________________________________________________
      ______________________________________________________________________________________________________________

   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 in the Additional Comments section below.

      Additional Comments: _____________________________________________________________________________________________
      _______________________________________________________________________________________________________________
      _______________________________________________________________________________________________________________
      _______________________________________________________________________________________________________________

   7. Date of eye examination: __________________________________

   Must be completed – Statement of vision not valid after 90 days from examination date
### 3. Doctor’s Information

Name of Optometrist or Ophthalmologist (Please print)  
Signature of Optometrist or Ophthalmologist  
Address (Please Print)  

<table>
<thead>
<tr>
<th>Street address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Phone Number: ___(______)_______________________  
Fax Number: ___(______)_______________________

### 4. Submission instructions

Once completed, please submit via mail, email or fax:

<table>
<thead>
<tr>
<th>Mailing address:</th>
<th>Email address:</th>
<th>Fax Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nebraska State Patrol</td>
<td><a href="mailto:nsp.chp@nebraska.gov">nsp.chp@nebraska.gov</a></td>
<td>(402) 479-4321</td>
</tr>
<tr>
<td>Criminal Identification Division</td>
<td></td>
<td></td>
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<tr>
<td>PO Box 94907</td>
<td></td>
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<tr>
<td>Lincoln, NE 68509-4907</td>
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FORM NOT VALID MORE THAN 90 DAYS AFTER THE EXAMINATION DATE