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 _____ Degrees Nasal

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

   _____° Nasal *(Left)* _____° Nasal *(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) _____
Street address *City* *State* *Zip Code*

Phone Number: ___(_____)_____

Fax Number: ___(_____)_____

4. Submission instructions

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

Mailing address:	Email address:	Fax Number:
Nebraska State Patrol Criminal Identification Division PO Box 94907 Lincoln, NE 68509-4907	nsp.chp@nebraska.gov	(402) 479-4321

FORM NOT VALID MORE THAN 90 DAYS AFTER THE EXAMINATION DATE