Central Services and Records Division
Reno/Sparks/Carson City (775) 684-4DMV (4368)
Las Vegas Area (702) 486-4DMV (4368)
Rural Nevada (877) 368-7828
Website: www.dmvnv.com

Physical Evaluation Form

Driver License Renewal By Mail

Sections 1 and 2 of this evaluation form must be completed by your physician and/or optometrist. Please return this evaluation with your application to renew your driver license by mail. We must receive this evaluation form within 90 days after the date of examination.

Driver's Name _____

Address _____

Soc. Sec. Number _____ Date of Birth _____ Age _____

Section 1 - Vision

	Without Corrective Lenses	With Corrective Lenses
Right Eye	20/	20/
Left Eye	20/	20/
Both Eyes	20/	20/

_____ _____
DMV Representative/Physician's/Optometrist's Signature | Date of Examination (must be within last 90 days)

_____ _____
Please print name of Physician/Optometrist | Phone Number

_____
Office Address of Physician/Optometrist

Does this person have a progressive disease or condition of the eye? ..... Yes No

Section 2 - Medical (This section must be completed by a licensed physician)

Does a medical condition exist that would prevent this patient from operating a motor vehicle safely? ..... Yes No

If "Yes", please explain: _____

Is this patient taking any medication that would affect his/her ability to drive safely? ..... Yes No

If "Yes", please explain: _____

_____ _____
Physician's Signature | Date of Examination (must be within last 90 days)

_____ _____
Please print name of Physician | Phone Number

_____
Office Address of Physician/Optometrist