Beyond Wellness

Chiropractic Center

Alternative vision evaluation, MCSA-5871

For your DOT visit at Beyond Wellness

Dr. Kevin P. Lyons, DC
5035 W W.T. Harris Blvd, Suite A
Charlotte, NC 28269
Office: 704-461-1836
Return fax: 704-246-5156

Return instructions

Bring the requested completed form to your DOT visit, or call the office to confirm the approved return method before sending medical records. Keep this cover sheet with the form so the return office is clear.

An ophthalmologist or optometrist completes this report when the alternative vision standard applies. Wearing glasses alone does not mean you need this form.

Timing: the examiner must receive the completed form and begin the examination within 45 calendar days after the appropriate clinician signs it. Plan that provider visit around your DOT appointment.

Complete only the sections assigned to you. Clinical findings, signatures, dates and qualification decisions have not been completed by the clinic in this packet.

https://beyondwellnesscc.com/dot-physical-charlotte/vision-records/

Form MCSA-5871

OMB No.: 2126-0006
Expiration Date: 03/31/2028

U.S. Department of Transportation
Federal Motor Carrier Safety Administration

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately 8 minutes per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Medical Programs Division, Federal Motor Carrier Safety Administration, 1200 New Jersey Avenue SE, Washington, DC 20590.

VISION EVALUATION REPORT

Name: _____ **DOB:** _____

Driver's License Number: _____ **State:** _____

Information for the Individual:

The medical examiner must receive this report and begin the physical qualification examination not more than **45** calendar days after an ophthalmologist or optometrist signs this report.

Information for the Ophthalmologist or Optometrist:

This individual is being evaluated as part of the process to determine whether the individual meets the vision standard of the Federal Motor Carrier Safety Administration (FMCSA) to operate a commercial motor vehicle in interstate commerce. This report is required to provide information for an individual who has "monocular vision," as defined by FMCSA, or did not meet FMCSA's vision standard at a physical qualification examination. An ophthalmologist or optometrist should complete this report to the best of the ophthalmologist's or optometrist's ability based on the evaluation of the individual and knowledge of the individual's medical history. The determination as to whether the individual meets the vision standard and is physically qualified to drive a commercial motor vehicle will be made by a medical examiner on FMCSA's National Registry of Certified Medical Examiners.

FMCSA defines monocular vision as:

(1) in the better eye, distant visual acuity of at least 20/40 (with or without corrective lenses) and field of vision of at least 70 degrees in the horizontal meridian; and

(2) in the worse eye, either distant visual acuity of less than 20/40 with corrective lenses or field of vision of less than 70 degrees in the horizontal meridian, or both.

For general informational purposes only, to meet FMCSA's monocular vision standard, an individual must:

(1) have in the better eye distant visual acuity of at least 20/40 (Snellen), with or without corrective lenses, and field of vision of at least 70 degrees in the horizontal meridian;

(2) be able to recognize the colors of traffic signals and devices showing standard red, green, and amber;

(3) have a stable vision deficiency; and

(4) have had sufficient time pass since the vision deficiency became stable to adapt to and compensate for the change in vision.

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Name: _____ **DOB:** _____

PLEASE CHECK/FILL IN REQUESTED INFORMATION (PLEASE PRINT):

1. I am: ☐ an ophthalmologist ☐ an optometrist

2. Date of vision evaluation *(MM/DD/YYYY)*: _____

3. Distant visual acuity (select N/A if there is no vision in an eye):
   Uncorrected: Right eye: 20/____ or N/A ☐ Left eye: 20/____ or N/A ☐
   Corrected: Right eye: 20/____ or N/A ☐ Left eye: 20/____ or N/A ☐
   Type of correction: ☐ Glasses ☐ Contacts

4. Field of vision, including central and peripheral fields, utilizing a testing modality that tests to at least 120 degrees in the horizontal. Formal perimetry is required. **Attach a copy of the formal perimetry test for each eye and interpret the results in degrees of field of vision.**
   Right eye: ____ degrees ("normal" or "full" are not acceptable)
   Left eye: ____ degrees ("normal" or "full" are not acceptable)
   Test used to determine results: _____ ATTACH FILE

5. Is the individual able to recognize the standard red, green, and amber traffic control signal colors? ☐ Yes ☐ No

6. Date of last comprehensive eye examination *(MM/DD/YYYY)*: _____ or ☐ Date unknown

7. Does the individual have monocular vision as it is defined by FMCSA? ☐ Yes ☐ No
   If yes, cause of the monocular vision (describe):
   _____
   _____

8. Date the monocular vision began *(MM/DD/YYYY)*: _____

9. Current treatment: _____ or ☐ N/A

10. Does the individual have any progressive eye condition or disease (e.g., macular edema, cataracts, glaucoma, or retinopathy)?
    ☐ Yes ☐ No
    If yes, provide the condition or disease, date of diagnosis, severity (mild, moderate, or severe), current treatment, and whether the condition is stable:
    a. Condition or disease: _____
    _____
    Date of diagnosis: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe
    Current treatment: _____
    Is condition stable? ☐ Yes ☐ No If no, why: _____

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Name: _____ **DOB:** _____

b. Condition or disease: _____

_____

Date of diagnosis: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Current treatment: _____

Is condition stable? ☐ Yes ☐ No If no, why: _____

c. Condition or disease: _____

_____

Date of diagnosis: _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Current treatment: _____

Is condition stable? ☐ Yes ☐ No If no, why: _____

11. In your medical opinion, is the individual's vision deficiency stable? ☐ Yes ☐ No

    If yes, provide the date the vision deficiency became stable *(MM/DD/YYYY)*: _____

12. In your medical opinion, has sufficient time passed since the vision deficiency became stable to allow the individual to adapt to and compensate for the change in vision and to drive a commercial motor vehicle safely?

    ☐ Yes ☐ No

13. In your medical opinion, is a vision evaluation required more often than annually? ☐ Yes ☐ No

    If yes, how often and why? _____

14. Additional comments *(attach additional pages as needed)*

_____

_____

_____

_____

ATTACH FILE

I attest that I am an ophthalmologist or optometrist and that the information provided is true and correct to the best of my knowledge.

Date	Printed Name and Medical Credential
Professional License Number and State	Signature
Phone Number	Email
Street Address	City, State, Zip Code

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