

## PEACE OFFICER REFRACTIVE SURGERY CLINICAL EXAMINATION REPORT

The California State Personnel Board requires that applicants for peace officer positions who have had refractive eye surgery submit regular reports from their doctors for one year. If you have had or plan to have refractive eye surgery of any kind, please take this package to your doctor.

Your doctor is to complete the reports as indicated and mail them directly to:

Office of Peace Officer Selection  
Peace Officer Appointment Section  
9838 Old Placerville Road, Suite B  
Sacramento, CA 95827

|  |           |
|--|-----------|
| CANDIDATE NAME (Last, First, Middle Initial)   | SSN       |
| ADDRESS (Street, City, State, Zip)   | TELEPHONE |
| CLASSIFICATION (Check all that apply)  |           |
| <input type="checkbox"/> CORRECTIONAL OFFICER <input type="checkbox"/> YOUTH CORRECTIONAL OFFICER <input type="checkbox"/> YOUTH CORRECTIONAL COUNSELOR <input type="checkbox"/> OTHER   |           |
| <input type="checkbox"/> CORRECTIONAL COUNSELOR <input type="checkbox"/> PAROLE AGENT I <input type="checkbox"/> FIRE FIGHTER, CF  |           |
| <b>AUTHORIZATION TO RELEASE INFORMATION</b>  |           |
| To determine my eligibility for employment as a peace officer with the California Department of Corrections and Rehabilitation (CDCR), I authorize you to release to CDCR any and all medical information and/or records concerning my vision. This authorization is valued until the selection process is complete. |           |
| CANDIDATE SIGNATURE  | DATE      |

## REFRACTIVE EYE SURGERY EVALUATION CRITERIA FOR OPTOMETRIST/OPHTHAMOLOGIST

Your patient is seeking employment as a peace officer, a public safety position and has informed us that he/she has undergone (or plans to undergo) refractive eye surgery (i.e. RK, PRK, Lasik, laser, etc.). He/she must demonstrate stable visual functions prior to appointment as follows:

1. Visual acuity in each eye must be stable over at least a 12 month period of time after surgery.
2. Visual acuity must meet the corrected and uncorrected standard for the class being tested.

### Classification

Correctional Officer  
Youth Correctional Officer  
Youth Correctional Counselor  
Medical Technical Assistant-P

### Visual Acuity Requirements

20/60 uncorrected in each eye and corrected to 20/20  
20/60 uncorrected in each eye and corrected to 20/20  
20/60 uncorrected in each eye and corrected to 20/20  
20/60 uncorrected in each eye and corrected to 20/20

3. Glare disability and contrast sensitivity must be normal.
4. Post-operative complications must have been resolved for at least six months.
5. On behalf of your patient, please supply the information requested below when the Clinical Examination Reports document stability.
  - A. Submit a copy of the operative reports and copies of all doctor's progress notes since surgery.
  - B. List the date(s) of surgery on each eye.
  - C. List the date that the applicant became free of post-operative complications.
  - D. List the surgical protocol followed (i.e. Saulson, Thorton, Ellis, other – please name)
  - E. List sensitivity to any environmental factors (i.e. heat, cold, smog, dust, etc.)
  - F. Complete and submit the Clinical Examination Reports.

The information will be used to determine your patient's stability of vision after refractive surgery. Visual acuity should be measured using a Bailey-Lovie acuity chart or other standardized chart used for acuity measurements. Acuity should be measured in the morning and again in the late afternoon (allowing at least 6 hours between exams). Percent glare disability should be measured in each eye before and after cyclopegia. Please list the instrument used and the expected normal values. All post-operative examinations must be at least three months apart for our purposes (this protocol does not preclude other examinations if you determine they are necessary). Cyclopegic exams should be performed after using 1% mydriacyl for paralysis of accommodation.

Please send the reports to the address listed above.

### PRE-OPERATIVE CLINICAL EXAMINATION REPORT

|  |    |    |                          |
|--|----|----|--------------------------|
| CANDIDATE NAME (Last, First, Middle Initial)       |    |    | SSN                      |
| EXAMINED BY  |    |    | EXAM DATE                |
| EXAMINER ADDRESS (Street, City, State, Zip)        |    |    | EXAMINER TELEPHONE       |
| VISUAL ACUITY WITHOUT CORRECTIONS (DIMLY LIT ROOM) | OD | OS | METHOD TO MEASURE ACUITY |
| MANIFEST REFRACTION                                | OD | OS |                          |
| TONOMETRY  | OD | OS |                          |
| DOCTOR'S PRINTED NAME                              |    |    | TELEPHONE NUMBER         |
| DOCTOR'S ADDRESS (Street, City, State, Zip)        |    |    |                          |
| DOCTOR SIGNATURE                                   |    |    | DATE                     |

**SIX MONTH POST OPERATIVE CLINICAL EXAMINATION REPORT**  
**INSTRUCTIONS FOR EXAMINER**

Please allow 6 hours between the morning and afternoon examinations.

Please use 1% mydriacyl for cycloplegia.

|  |                   |              |                                 |                                 |         |
|--|-------------------|--------------|---------------------------------|---------------------------------|---------|
| CANDIDATE NAME (Last, First, Middle Initial)       |                   |              |                                 | SSN                             |         |
| EXAMINED BY  |                   |              |                                 | EXAM DATE                       |         |
| SURGERY DATE LEFT EYE                              |                   |              | SURGERY DATE RIGHT EYE          |                                 |         |
| EXAMINER ADDRESS (Street, City, State, Zip)        |                   |              |                                 | EXAMINER TELEPHONE              |         |
| VISUAL ACUITY WITHOUT CORRECTIONS (DIMLY LIT ROOM) |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| VISUAL ACUITY WITH CORRECTION (DIMLY LIT ROOM)     |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| METHOD TO MEASURE VISUAL ACUITY                    |                   |              |                                 |                                 |         |
| MANIFEST REFRACTION                                |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| TONOMETRY  |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| CYCLOPLEGIC EXAM                                   | PUPILLARY OD      | PUPILLARY OS | REFRACTION AFTER CYCLOPLEGIA OD | REFRACTION AFTER CYCLOPLEGIA OS |         |
| CYCLOPLEGIC EXAM                                   | SLIT LAMP EXAM OD |              | SLIT LAMP EXAM OS               |                                 |         |
| DOCTOR'S PRINTED NAME                              |                   |              |                                 | TELEPHONE NUMBER                |         |
| DOCTOR'S ADDRESS (Street, City, State, Zip)        |                   |              |                                 |                                 |         |
| DOCTOR SIGNATURE                                   |                   |              |                                 | DATE                            |         |

## NINE MONTH POST OPERATIVE CLINICAL EXAMINATION REPORT

### INSTRUCTIONS FOR EXAMINER

Please allow 6 hours between the morning and afternoon examinations.

Please use 1% mydriacyl for cycloplegia.

|  |                   |              |                                 |                                 |         |
|--|-------------------|--------------|---------------------------------|---------------------------------|---------|
| CANDIDATE NAME (Last, First, Middle Initial)       |                   |              |                                 | SSN                             |         |
| EXAMINED BY  |                   |              |                                 | EXAM DATE                       |         |
| SURGERY DATE LEFT EYE                              |                   |              | SURGERY DATE RIGHT EYE          |                                 |         |
| EXAMINER ADDRESS (Street, City, State, Zip)        |                   |              |                                 | EXAMINER TELEPHONE              |         |
| VISUAL ACUITY WITHOUT CORRECTIONS (DIMLY LIT ROOM) |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| VISUAL ACUITY WITH CORRECTION (DIMLY LIT ROOM)     |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| METHOD TO MEASURE VISUAL ACUITY                    |                   |              |                                 |                                 |         |
| MANIFEST REFRACTION                                |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| TONOMETRY  |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| CYCLOPLEGIC EXAM                                   | PUPILLARY OD      | PUPILLARY OS | REFRACTION AFTER CYCLOPLEGIA OD | REFRACTION AFTER CYCLOPLEGIA OS |         |
| CYCLOPLEGIC EXAM                                   | SLIT LAMP EXAM OD |              | SLIT LAMP EXAM OS               |                                 |         |
| DOCTOR'S PRINTED NAME                              |                   |              |                                 | TELEPHONE NUMBER                |         |
| DOCTOR'S ADDRESS (Street, City, State, Zip)        |                   |              |                                 |                                 |         |
| DOCTOR SIGNATURE                                   |                   |              |                                 | DATE                            |         |

## TWELVE MONTH POST OPERATIVE CLINICAL EXAMINATION REPORT

### INSTRUCTIONS FOR EXAMINER

Please allow 6 hours between the morning and afternoon examinations.

Please use 1% mydracyl for cycloplegia.

|  |                   |              |                                 |                                 |         |
|--|-------------------|--------------|---------------------------------|---------------------------------|---------|
| CANDIDATE NAME (Last, First, Middle Initial)       |                   |              |                                 | SSN                             |         |
| EXAMINED BY  |                   |              |                                 | EXAM DATE                       |         |
| SURGERY DATE LEFT EYE                              |                   |              | SURGERY DATE RIGHT EYE          |                                 |         |
| EXAMINER ADDRESS (Street, City, State, Zip)        |                   |              |                                 | EXAMINER TELEPHONE              |         |
| VISUAL ACUITY WITHOUT CORRECTIONS (DIMLY LIT ROOM) |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| VISUAL ACUITY WITH CORRECTION (DIMLY LIT ROOM)     |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| METHOD TO MEASURE VISUAL ACUITY                    |                   |              |                                 |                                 |         |
| MANIFEST REFRACTION                                |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| TONOMETRY  |                   | A.M. OD      | A.M. OS                         | P.M. OD                         | P.M. OS |
| CYCLOPLEGIC EXAM                                   | PUPILLARY OD      | PUPILLARY OS | REFRACTION AFTER CYCLOPLEGIA OD | REFRACTION AFTER CYCLOPLEGIA OS |         |
| CYCLOPLEGIC EXAM                                   | SLIT LAMP EXAM OD |              | SLIT LAMP EXAM OS               |                                 |         |
| DOCTOR'S PRINTED NAME                              |                   |              |                                 | TELEPHONE NUMBER                |         |
| DOCTOR'S ADDRESS (Street, City, State, Zip)        |                   |              |                                 |                                 |         |
| DOCTOR SIGNATURE                                   |                   |              |                                 | DATE                            |         |