

## PEACE OFFICER VISION VERIFICATION

**Candidate's Name:**

\_\_\_\_\_  
PRINT                      Last    First    MI

**Address:**

\_\_\_\_\_  
Street

**Application No.** \_\_\_\_\_

**Telephone  
Number:** (       )

\_\_\_\_\_  
City    State                      ZIP

**CLASSIFICATION(S):**    CO    YCO    YCC    PA I    OTHER: \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION

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 valid until the selection process is completed.

**Candidate's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### TO OPTOMETRIST/OPHTHALMOLOGIST:

Your patient has applied for a Peace Officer position with CDCR and we need verification that his/her vision meets our vision requirements. We also require disclosure of the means of correction. Please evaluate your patient's visual acuity and indicate both corrected and uncorrected levels of acuity in the designated area below. The information provided will normally be used by non-medical staff; therefore, **in addition to listing the acuity measurements, all questions must be answered.**

1. Has the patient had refractive eye surgery? (i.e., RK, PRK, Lasik, etc.) Yes     No   
If "Yes", indicate date of last surgery: \_\_\_\_\_
2. Is the patient's visual acuity 20/20 or better in each eye uncorrected? Yes     No
3. If the patient's visual acuity is not 20/20 or better in each eye uncorrected, is his/her visual acuity corrected to 20/20 in each eye? Yes     No
4. What method(s) of correction does your patient currently use?                      Glasses     Hard/Semi Rigid contact lenses     Soft contact lenses   
If contact lenses are used, has your patient been a successful contact lenses wearer for the last 12 months? Yes     No
5. If "No", indicate the date the patient began using contact lenses: \_\_\_\_\_
6. Document the patient's uncorrected and corrected visual acuity.

**Uncorrected Visual Acuity**

Right eye: \_\_\_\_\_                      Left eye: \_\_\_\_\_

**Corrected Visual Acuity**

Right eye: \_\_\_\_\_                      Left eye: \_\_\_\_\_

7. In the section below, please complete the prescription information for the correction in Item 3.

Glasses					Contact Lenses			
Rx	Sphere	Cylinder	Axis	Prism	Rx	Power	Base Curve	Diameter
D I S T	OD				OD			
	OS				OS			
A D D	OD	+	Bifocal Type					
	OS	+	Trifocal Type					

Doctor's Original Signature	Date
Doctor's Printed Name	Telephone Number
Doctor's Address	
City, State ZIP	