STATE OF CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION
OPOS 07C (2/12)

OFFICE OF PEACE OFFICER SELECTION
PEACE OFFICER APPOINTMENT SECTION

PEACE OFFICER VISION VERIFICATION

Candidate's Name: _____
PRINT *Last* *First* *MI*

Address: _____ **Application No.** _____
Street

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
DIST	OD					OD			
	OS					OS			
ADD	OD	+	Bifocal Type						
	OS	+	Trifocal Type						

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