State of California
Office of Peace Officer Selection

Department of Corrections and Rehabilitation
Peace Officer Appointment Section

PEACE OFFICER VISION VERIFICATION

OPOS 201

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 their 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., LASIK, LASEK, PRK, SMILE) etc.) If "Yes", indicate date of last surgery: ______________ Yes ❑ No ❑
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 Rigid Gas Permeable Contact Lenses Soft Contact Lenses Scleral Rigid Gas Permeable Contact Lenses Hybrid Contact Lenses
   If contact lenses are used, has your patient been a successful contact lenses wearer for the last six 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					
Rx		Sphere	Cylinder	Axis	Prism
DIST	OD				
	OS				
ADD	OD	+	Bifocal Type		
	OS	+	Trifocal Type		

Contact Lenses			
Rx	Power	Base Curve	Diameter
OD			
OS			

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