APPLICANT VISION EXAMINATION REPORT

Note: Please ensure all areas are fully completed

APPLICANT PARTICULARS

SURNAME: GIVEN NAMES:

ADDRESS: POSTAL CODE

FINDINGS OF EYE EXAMINER Date of Examination: _____

1. Visual Acuity Test	Visual Acuity—Far		Visual Acuity—Near	
	Uncorrected	Corrected	Uncorrected	Corrected
Right Eye				
Left Eye				
Both Eyes				
Method of Measurement	[ ] Snellen [ ] Decimal [ ]AMA		[ ] Snellen [ ] Jaegar [ ]Point	

2. Visual Correction Frequency of Use

[ ] Nil [ ] Eyeglasses [ ] Contact Lenses [ ] For Permanent Use [ ] For occasional use

3. Corrective Procedure

[ ] Nil [ ] Radial Keratotomy [ ] Orthokeratology [ ] Laser Keratectomy [ ] X-chrom lenses
[ ] Other Details of corrective procedures: (Include dates of procedure, prior vision, complications, prognosis. If space is insufficient, attach separate page.)

4. Visual Fields

A normal visual field for the purpose of this examination is defined as a vision of 120’ in each in the horizontal field and the absence of scotoma.

[ ] Normal [ ] Defective Details:

5. Diplopia

[ ] Absent

[ ] Present Details:

6. Colour Vision
Use Ishihara Pseudo-Isochromatic plates.
If deficiency is found, administer Farnsworth D-15 as an alternatively acceptable test. In the event of a colour vision deficiency, kindly attach Actual Ishihara and Farnsworth D-15 results for Subsequent review.

[ ] Normal

[ ] Deficiency

7. Other conditions or comments. (If space is insufficient, please attach separate page)

_____

_____

_____

EXAMINER NAME:

_____

SURNAME: GIVEN NAMES INITALS

_____

ADDRESS (Number Street, Suite #, City)

Telephone #: _____

Fax #: _____

SIGNATURE OF PHYSICIAN:

_____

Pursuant to S39(2) of the Freedom of Information and Protection of Privacy Act, you are hereby notified that personal information about you is being collected during the recruitment process for the purpose of assessing your qualifications in relation to your application for employment.