

Report of Medical Examination/Treatment—Vision

For use of this form, see USMEPCOM Reg 40-1

Patient's Name: _____ DOB: _____

Please provide the following information about your patient's **manifest refraction** and best **corrected visual acuities (distant and near)**. *Measurements must be completed within the past 12 months.*

Distant vision Corr. to OD: 20/____ OS: 20/____ **Near vision** Corr. to OD: 20/____ OS: 20/____

Date of manifest refraction: _____

OD: Sphere _____ Cylinder: _____ Axis: _____

OS: Sphere _____ Cylinder: _____ Axis: _____

IF ALL of the following apply, *then no further evaluations are needed.*

- Spherical equivalents are $\leq \pm 8.00$ OU
- Cylinders are $\leq \pm 3.00$ OU
- Distant vision is correctable to 20/40 or better OU
- Near vision is correctable to 20/40 or better in the better eye

OTHERWISE, please complete the following evaluations as applicable:

- IF the **SPHERICAL EQUIVALENT** in either eye is $> \pm 8.00$, please also complete:
 - Dilated eye exam
 - Comments on the presence or absence of any retinal pathology
- IF the **CYLINDER** in either eye is $> \pm 3.00$ please also complete:
 - Dilated eye exam
 - Intraocular pressure measurements
 - Corneal topography (please include color copies of the images)
 - Comments on the presence or absence of corneal ectasia, keratoconus, or any retinal pathology
- IF the best corrected **distant** visual acuity is **NOT** 20/40 or better for either eye AND/OR the best corrected **near** visual acuity is **NOT** 20/40 or better in the better eye, please also complete:
 - Dilated eye exam
 - Intraocular pressure measurements
 - Corneal topography (please include color copies of the images)
- Please comment on any other abnormalities noted as a result of your evaluation.

Please use the back of this form to provide requested information, or attach your office visit notes.

Provider's Name: _____ Signature: _____ Date: _____

Office Address: _____ Office Phone: _____

Privacy Act Statement

Authority: Sections 505, 508, 510, and 3012 of Title 10 U.S. Code and Executive Order 9397. Principal Purpose: Information collected will be used to assist in the military qualification process. Routine Uses: Blanket routine use disclosures as described in USMEPCOM REG 40-1. Disclosure: Voluntary

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Patient's Name: _____ DOB: _____

Provider's examination findings:

Provider's Name: _____ Signature: _____ Date: _____

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