



**SOUTH COAST BRITISH COLUMBIA
TRANSPORTATION AUTHORITY
POLICE SERVICE**

307 Columbia Street, New Westminster, BC V3L 1A7
Telephone: 604-515-8300 Fax: 604-515-8361

VISION REPORT FOR POLICE SERVICE

TO BE COMPLETED BY THE APPLICANT

Name of Applicant: _____
Surname Given Name Initial

Address of Applicant: _____
Street

_____ City Province Postal Code

Have you ever had eye surgery? Yes No If yes, please indicate the date and type of procedure:

TO BE COMPLETED BY THE ATTENDING OPHTHAMOLOGIST / OPTOMETRIST

Date of examination: _____
yy/mm/dd

		Without Visual Aid	With best possible corrections
1. Visual Acuity	Right Eye	20/	20/
	Left Eye	20/	20/
	Both Eyes	20/	20/
2. Horizontal Field of Vision		Temporal	Nasal
	Right Eye		
	Left Eye		

Binocular Vision (Depth Perception) Normal _____ Abnormal _____

COMMENTS: _____

3. Colour Vision determined by Pseudo-Isochromatic Plates or Farnsworth-Munsell
 Normal _____ Abnormal _____

COMMENTS: _____

ATTENDING OPHTHALMOLOGIST / OPTOMETRIST

Name: _____ Telephone: _____

Address: _____

Signature of Ophthalmologist / Optometrist _____
Date (yy/mm/dd)

Signature of Parent or Guardian _____
Date (yy/mm/dd)