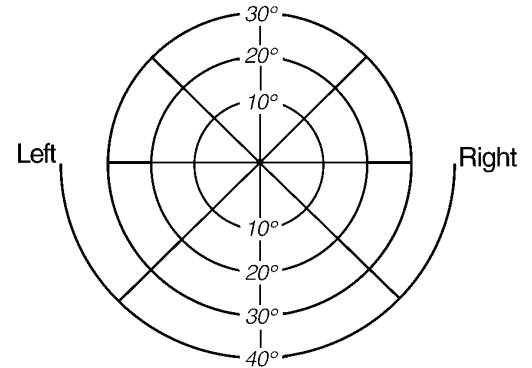
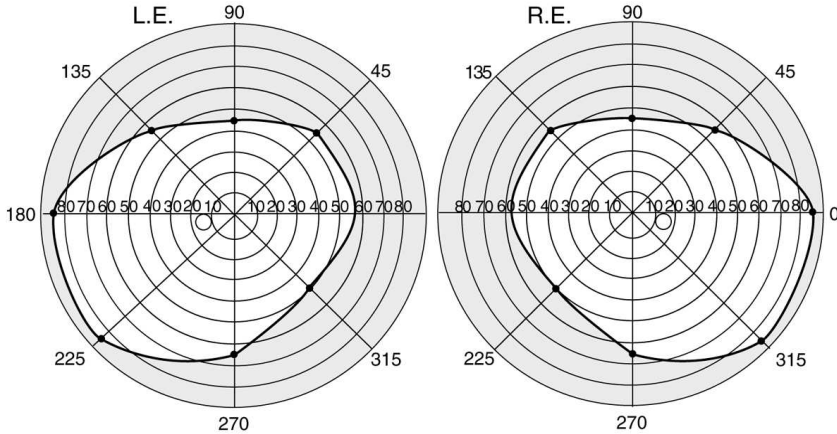


Worker's name: \_\_\_\_\_ DOI: \_\_\_\_\_ WCD #: \_\_\_\_\_

**Visual acuity:** Report the central visual acuity for each eye, distance and near vision, through best correction recommended by the worker's physician.

	L.E.	R.E.
Distance vision, reported in standard increments of Snellen notation	/	/
If distance vision is less than 20/400, can the worker count fingers at four feet?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Near vision, reported in Snellen 14/14 notation. Revised Jaeger or American point type units		
Natural lens	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Implanted prosthetic lens	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Aphakia	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no



**Visual field deficits:**  N/A

Measure each visual field using a Goldmann perimeter with a III / 4e stimulus. Report the results on either:

1. a perimetric chart which indicates the extent of retained vision out to 90 degrees for each of the eight standard 45-degree meridians, as reproduced above, or
2. a monocular Esterman grid

**Impairments of lacrimal system:**  N/A

If too little or too much tearing restricts the worker from any part of regular work, specify the affected eye and whether the condition:

- is a nuisance but does not prevent most regular work activities
- prevents some regular work-related activities
- prevents most regular work-related activities

**Ocular motility:**  N/A

Report binocular diplopia in degrees along the eight standard meridians, as reproduced above.

<b>Additional ocular disturbances</b> <input type="checkbox"/> N/A			
Indicate the affected eye:			
	Mild	Moderate	Severe
Glare (photophobia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Monocular diplopia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stereopsis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Examining physician name and title (print or type): \_\_\_\_\_

Signature: \_\_\_\_\_ Date of examination: \_\_\_\_\_