

Vision Evaluation

National Academy of Railroad Sciences
 JCCC Conductor Program
 12345 College Blvd., Overland Park, KS 66210 913-469-3857



Federal Certification 49 CFR Part 240 Vision Examination Form for NARS Applicants

Part 1 – Patient Information						
Last Name		First Name			Middle Initial	
Street Address				City		
State		Zip		Telephone Number		
Part 2 – Instructions to the Examiner						
In accordance with Federal Railroad Administration Regulation 49 CFR Part 240: You are to examine the above-named patient for visual acuity.			Visual Acuity: 1. Distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses or 2. Distant visual acuity separately corrected to at least 20/40 (Snellen) with corrective and distance binocular acuity of at least 20/40 (Snellen) in both eyes with or without corrective lenses. FIELD OF VISION MUST BE CHECKED AND RECORDED			
Distant Vision		Near Vision		Field of Vision		
<u>Without Glasses/Contacts</u>						
20/_____	20/_____					
Left	Right			Left	Right	
<u>With Glasses/Contacts</u>		Are glasses required for DISTANT vision? <input type="checkbox"/> Yes <input type="checkbox"/> No		Required		
20/_____	20/_____			<input type="checkbox"/> Pass <input type="checkbox"/> Fail		
<input type="checkbox"/> Pass <input type="checkbox"/> Fail			At least 70 degrees in the horizontal meridian in each eye			
Part 3 – Color Vision (Ishihara Charts – Pseudoisochromatic Plates Preferred)						
1. Test Type:						
<input type="checkbox"/> Ishihara		<input type="checkbox"/> Isochromatic		<input type="checkbox"/> Other:		
Number of Plates/Charts Viewed _____		Number of Plates/Charts Missed _____		Actual Plate Numbers Missed _____		
2. Color Vision:						
<input type="checkbox"/> Color Vision Normal			<input type="checkbox"/> Color Vision Deficient			

Part 4 – Validation of Patient

The examining physician must validate patient identification with a photo ID:

Validated? Yes No

Physician or Technician: _____

Address: _____

Phone Number: _____

Physician or Technician Signature: _____

Examination Date: _____

******Patient is responsible for payment******

***This signed and completed form (pgs 1 & 2) must be faxed from the doctor's office to: 913-469-3864.**

