**To issue a Texas Intrastate Vision Waiver, the Department of Public Safety must receive the following documents:**

1. A Texas Intrastate Vision Waiver Application completed by the applicant.
2. A Driver License Office Vision Examination form completed and by Department of Public Safety driver license office personnel.
3. The Medical Examination Report completed by a licensed medical examiner.

***The License and Record Service Section of the Department of Public Safety must receive vision/physical examination results within 45 days of the date of the exam. Incomplete documents will be returned to the applicant for completion. Completed Texas Intrastate Vision Waivers may be faxed, emailed, or mailed to the Department of Public Safety.***

**Completed applications are to be mailed to:**

**TEXAS DEPARTMENT OF PUBLIC SAFETY**
**LICENSE AND RECORD SERVICE**
**ATTN: CDL**
**P.O. BOX 4087 AUSTIN, TEXAS 78773-0320**

**Completed applications are to be emailed to:**

**TexasCDL@DPS.TEXAS.GOV**

**Completed applications are to be faxed to:**

**(512) 424-2002**

**IF YOUR VISION WAIVER IS APPROVED, VISION WAIVERS ARE VALID FOR TWO (2) YEARS FROM THE EXAMINATION DATE, UNLESS THE MEDICAL EXAMINER SPECI FIES A SHORTER PERIOD. WAIVER RECIPIENTS MUST HAVE THE 'M' (CDL-INTRASTATE COMMERCE ONLY) AND 'P' (VALID TEXAS VISION WAIVER REQUIRED) RESTRICTIONS ADDED TO THEIR LICENSE. IF CORRECTIVE LENSES ARE REQUIRED TO MEET TEXAS VISION WAIVER CRITERIUM, THE 'A' RESTRICTION (CORRECTIVE LENSES) WILL BE ADDED AS WELL.**

**IF YOU HAVE ANY QUESTIONS REGARDING THE WAIVER APPLICATION PROCESS, YOU MAY CONTACT THE CUSTOMER CONTACT CENTER AT (512) 424-2600 AND SELECT "DRIVER LICENSE INFORMATION."**

**IF THIS APPLICATION PACKET IS NOT COMPLETED IN FULL AND RETURNED TO THIS OFFICE WITHIN 45 DAYS OF THE PHYSICAL EXAMINATION DATE, YOUR REQUEST FOR A VISION WAIVER MAY BE DENIED.**

# TEXAS INTRASTATE VISION WAIVER APPLICATION

| 1. Driver Name | 2. Social Security Number | 3. Birth date |
|---|---|---|
| (Last, First, Middle) | – – | MM/DD/YEAR |

| 4. Driver License Number | 5. Street Address |
|---|---|
| | |

| 6. City, State and Zip Code | 7. Telephone Number |
|---|---|
| | ( ) |

☐ **Renewal** **Current Waiver Expires** _____ ☐ **New Application**

**I hereby certify that if I am arrested, cited for or convicted of any disqualifying offense or other moving violation during the period my vision waiver application is pending, I will immediately report such arrests, citations or convictions to the Texas Department of Public Safety. I understand that a vision waiver granted under Title 37, Texas Administrative Code, Section 16.9 does not exempt me from meeting all other driver qualifications required under the Federal Motor Carrier Regulations, Part 391.41.**

**I do solemnly swear or affirm that I am the person named and described herein and that this affidavit is true and correct. Making a false statement under oath may subject the maker of the statement to perjury charges pursuant to Section 37.02 of the Penal Code.**

**Signature of Applicant**

_____

**Sworn to and subscribed before me on this** _____ **day of** _____, **20**_____

_____

**Notary Public or Authorized Officer**

# TEXAS INTRASTATE VISION WAIVER

## *Driver License Office Vision Examination*

| | | |
|---|---|---|
| 1. | TX Driver License Number | |
| 2. | Applicant Name (Last, first, middle) | |
| 3. | Station Number | |
| 4. | Station Location | |
| 5. | DL Employee Number | |

***Applicants must have 20/40 (Snellen) or better distant visual acuity with or without corrective lenses in the better eye or if the applicant's vision is uncorrectable in one eye and the applicant does not wear corrective lenses then uncorrected vision must be 20/25 (Snellen) in the better eye to be eligible for an intrastate vision waiver.***

| 6. | Visual Acuity | Right Eye | Left Eye | Both Eyes | 7. | Color Perception | |
|---|---|---|---|---|---|---|---|
| | Uncorrected | 20/ | 20/ | 20/ | | Normal | |
| | Corrected | 20/ | 20/ | 20/ | | Color Blind | |

***If the applicant disputes the results of the Snellen examination, he/she should be instructed to have a more detailed examination performed by a vision specialist. A CDL will not be issued or renewed if the applicant cannot meet the vision standards specified in 49 CFR, Part 391.41(b)(10). A driver wishing to renew a CDL must downgrade to a non-CDL license and complete application for a Texas Intrastate Vision Waiver. A driver who operates a motor vehicle in intrastate commerce, not transporting property requiring a hazardous material placard, and was regularly employed prior to August 28, 1989, is not required to meet the medical standards set forth in the Federal Motor Carrier Safety Regulations.***

**Signature of DL Employee** **Date** **Signature of Applicant**

CDL-36 (Rev. 02/12)

# Medical Examination Report
## FOR COMMERCIAL DRIVERS

**1. Driver's Information** **(To be completed by driver)** ****APPLICANT MUST SIGN LAST PAGE.**

| Driver's Name (Last, First, Middle) | Social Security Number | Birth date MM/DD/YEAR | Age | Sex | | **Date of Examination** |
|---|---|---|---|---|---|---|
| | - - | | | ○ M ○ F | ○ New Application ○ Renewal | |

| Resident Address | Mailing Address | Work Tel: ( ) Home Tel: ( ) | Driver License Number | Class of License | CDL |
|---|---|---|---|---|---|
| | | | | ○ A ○ B ○ C | ○ Yes ○ No |

**2. Health History** **(To be completed by medical examiner)** ***See Instructions to the Medical Examiner for guidance.***

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Injury or Illness in the past 5 years ? | ☐ | ☐ | Lung disease, emphysema, asthma | ☐ | ☐ | Chronic low back pain |
| ☐ | ☐ | Head or spinal cord injuries | ☐ | ☐ | Kidney disease | ☐ | ☐ | Sexually transmitted disease |
| ☐ | ☐ | Seizures, convulsions or fainting spells | ☐ | ☐ | Liver disease | ☐ | ☐ | Regular, frequent alcohol use |
| | ☐ | Medication ? _____ | ☐ | ☐ | Gastrointestinal disease | ☐ | ☐ | Narcotic or habit forming drug use |
| ☐ | ☐ | Vision impairment (other than corrective lenses) | ☐ | ☐ | Diabetes or elevated blood sugar | ☐ | | Other _____ |
| ☐ | ☐ | Hearing disorder, hearing loss, balance loss | | ☐ | Diet | | | _____ |
| ☐ | ☐ | Heart attack, cardiovascular disease | | ☐ | Oral medication | | | _____ |
| | ☐ | Medication ? _____ | | ☐ | Insulin injection | | | _____ |
| ☐ | ☐ | Heart surgery (valve replacement, bypass, angioplasty, etc.) | ☐ | ☐ | Nervous or psychiatric disorders | | | _____ |
| ☐ | ☐ | Hypertension | ☐ | ☐ | Sleep disorders, insomnia, sleep apnia, etc. | | | _____ |
| | ☐ | Medication ? _____ | ☐ | ☐ | Stroke or paralysis | | | _____ |
| ☐ | ☐ | Muscular disease | ☐ | ☐ | Missing or impaired limb | | | _____ |
| ☐ | ☐ | Shortness of breath | ☐ | ☐ | Spinal injury or disease | | | _____ |

(The medical examiner must review and discuss any 'yes' answers with the driver, including potential impact of medications on driving ability.)

_____

_____

**APPLICANT NAME:** **DRIVER LICENSE NUMBER:**

# TESTING (Medical Examiner to complete sections 3 through 5)

## 3. VISION

**Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.**

**INSTRUCTIONS:** *When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distant vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious.* ***Monocular drivers must be able to demonstrate 20/25 or better distant visual acuity without corrective lenses or 20/40 or better distant visual acuity with corrective lenses in the good eye. If the use of telescopic lenses is required to meet visual acuity standards, a comprehensive driving examination is required.***

| ACUITY | UNCORRECTED | CORRECTED | HORIZONTAL FIELD OF VISION |
|---|---|---|---|
| Right Eye | 20/ | 20/ | Right Eye |
| Left Eye | 20/ | 20/ | Left Eye |
| Both Eyes | 20/ | 20/ | |

**Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors ?**

Yes ☐ No ☐

**Monocular vision:**

Yes ☐ No ☐

**Complete next line only if vision testing is done by an ophthalmologist or optometrist.**

| Date of Examination | Name of Ophthalmologist or Optometrist | Telephone Number | License number/State of Issue | Signature |
|---|---|---|---|---|
| | | | | |

## 4. HEARING

**Standard: a) Must first perceive forced whispered voice ≥ 5 ft., with or without hearing aid, or b) average hearing loss in better ear ≤ 40dB.**

☐ Check if hearing aid used for tests. ☐ Check if hearing aid required to meet standard.

**INSTRUCTIONS:** *To convert audiometric test results from ISO to ANSI, -14dB from ISO for 500 Hz, -10 dB for 1,000 Hz, -8.5 dB for 2,000 Hz. To average, add the readings for three frequencies and divide by three.*

| a) Record distance from individual at which forced whispered voice can first be heard. | Right Ear Feet | Left Ear Feet |
|---|---|---|
| | | |

**OR**

| b) If audiometer is used, record hearing loss in decibels. (acc. To ANSI Z24.5-1951) | Right Ear | | | Left Ear | | |
|---|---|---|---|---|---|---|
| | 500 Hz | 1000 Hz | 2000 Hz | 500 Hz | 1000 Hz | 2000 Hz |
| | Average: | | | Average: | | |

## 5. BLOOD PRESSURE / PULSE RATE

**Numerical readings must be recorded.**

| Blood Pressure | Systolic | Diastolic |
|---|---|---|
| | | |

| Pulse Rate | ☐ Regular ☐ Irregular |
|---|---|

*Driver qualified if < 160 / 90 on initial examination.*

**Medical Examiner should take at least 2 readings to confirm blood pressure.**

Guidelines for Blood Pressure Evaluation

| On Initial Exam | Within 3 months | Certify |
|---|---|---|
| If 161-180 and/or 91-104, qualify for 3 months only. | If ≤ 160 and/or 90, qualify for 1 yr. Document Rx & control the third month. | Annually if acceptable BP is maintained. |
| If > 180 and/or 104, not qualified until reduced to < 181/105. Then qualify for 3 months only. | If ≤ 160 and/or 90, qualify for 6 months. Document Rx and control the third month. | Biannually |

**APPLICANT NAME:** **DRIVER LICENSE NUMBER:**

# TESTING (Medical Examiner to complete sections 6 and 7)

## 6. LABORATORY AND OTHER TEST FINDINGS

**Numerical readings must be recorded.**

*Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.*

| | SP. GR. | PROTEIN | BLOOD | SUGAR |
|---|---|---|---|---|
| URINE SPECIMEN | | | | |

**Other Testing *(Describe and record)***

## 7. PHYSICAL EXAMINATION

**Height:** _____ (in.) **Weight:** _____ (lbs.)

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check **YES** if there are any abnormalities. Check **NO** if the body system is normal. Discuss any **YES** answers in detail in the space on the last page and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for.

See ***Instructions to the Medical Examiner*** for guidance.

| BODY SYSTEM | CHECK FOR: | YES* | NO |
|---|---|---|---|
| 1. General Appearance | Marked overweight, tremor, signs of alcoholism, problem drinking or drug abuse. | | |
| 2. Eyes | Pupillary equality, reaction to light, accomodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, aphakia, glaucoma, macular degeneration. | | |
| 3. Ears | Middle ear disease, occlusion of external canal, perforated eardrums. | | |
| 4. Mouth and Throat | Irremediable deformities likely to interfere with breathing or swallowing. | | |

(OVER)

**APPLICANT NAME:** **DRIVER LICENSE NUMBER:**

# TESTING (Medical Examiner to complete section 7)

## 7. PHYSICAL EXAMINATION (continued)

| BODY SYSTEM | CHECK FOR: | YES* | NO |
|---|---|---|---|
| 5. Heart | Murmurs, extra sound, enlarged heart, pacemaker. | | |
| 6. Lungs and chest not including breast exam. | Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rales, impaired respiratory tunction, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest. | | |
| 7. Abdomen and Viscera | Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness. | | |
| 8. Vascular System | Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins. | | |
| 9. Genito-urinary System | Hernias | | |
| 10. Extremities - Limb impaired. Driver be subject to SPE certificate if otherwise qualified. | Loss or impairment of leg, foot, toe, arm hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly. | | |
| 11. Spine, other musculoskeletal | Previous surgery, deformities, limitation of motion, tenderness. | | |
| 12. Neurological | Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia. | | |

*** Comments:** _____

**Note certification status here. See *Instructions to the Medical Examiner* for guidance.**

☐ Qualifies for 2 year ☐ vision ☐ limb waiver certificate.

☐ Does not meet physical standards.

☐ Meets physical standards, but periodic evaluation required.

Due to _____ driver qualified only for:

☐ 3 months ☐ 1 year

☐ 6 months ☐ Other

_____
Medical Examiner's Signature

_____
Medical Examiner's Name (print)

_____ _____
Certificate number and State of issue

Address: _____

_____

**Applicant's Signature** _____ Telephone number: ( ) _____