



## Inspector Certification Eye Examination Form

### Applicant Information: Please Print Clearly

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Certification # (if applicable) \_\_\_\_\_ Member # (if applicable) \_\_\_\_\_

Have you ever had an eyesight deficiency brought to your attention? Yes \_\_\_\_ No \_\_\_\_

Do you now wear corrective lenses to aid your eyesight? Yes \_\_\_\_ No \_\_\_\_

Have you ever received surgical treatment for your eyes? Yes \_\_\_\_ No \_\_\_\_

If Yes, please explain.

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### To Applicants:

This form must be submitted in conjunction with your Supervisor Affidavit, Proof of Insurance and, Inspector Portfolio at the time you submit your Inspector Certification Application. Eye examinations must be administered by an Ophthalmologist, Optometrist, Medical Doctor, Registered Nurse or Certified Physician's Assistant. Examinations must be performed within six (6) months prior to exam.

All applicants must pass an eye examination, with or without corrective lenses, to provide 20/30 or greater acuity both for near and distant acuity. All applicants must take a color perception test. If an applicant is colorblind, this does NOT disqualify the applicant, however, if the applicant is colorblind a letter from the employer's supervisor stating acknowledgement must be submitted before testing.

Applicant Signature \_\_\_\_\_

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### TO BE COMPLETED BY THE EYE EXAMINER

Please verify the customer's near and distant acuity using Snellen Chart or Projection Chart. Acuity must be correctable to at least 20/30 or greater.

Examiner Name \_\_\_\_\_ Exam Date \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State/Providence \_\_\_\_\_ Zip/ Postal Code \_\_\_\_\_

Country \_\_\_\_\_

**Examiner Professional Status** *(Please check only one)*

Ophthalmologist\_\_\_ Optometrist\_\_\_ Medical Doctor\_\_\_ Registered Nurse\_\_\_ Certified Physician's Assistant \_\_\_

**State/Prov. License number** \_\_\_\_\_

Applicant wears glasses or contact lenses: Near Only \_\_\_\_\_ Distant Only \_\_\_\_\_ Constant \_\_\_\_\_

<b>Acuity</b>	<b>Unaided</b>	<b>With Correction</b>
<b>Distant Acuity</b>	Right 20/____	Right 20/____
	Left 20/____	Left 20/____
	Both 20/____	Both 20/____
<b>Near Acuity</b>	Right 20/____	Right 20/____
	Left 20/____	Left 20/____
	Both 20/____	Both 20/____

**Color Perception**

Applicant is Red/Green Colorblind \_\_\_\_\_

Applicant is Blue/Yellow Colorblind \_\_\_\_\_

Applicant is not Colorblind \_\_\_\_\_

**Examiners Name** \_\_\_\_\_

**Examiners Signature** \_\_\_\_\_

**Date** \_\_\_\_\_