



Vision Examination of Applicant
 Confidential
 Regina Police Service

| |
|--------------|
| File Number: |
| Date: |

| | | | |
|-----------------------------|---------------------|-----------------|--------------------|
| Name | Given Names | D.O.B. | |
| Street Address | City or Town | Province | Postal Code |
| Place of Examination | | Province | |

1. **Visual Acuity** (Minimum acceptable acuity is 20/60 in both eyes or 20/40 in one eye and 20/100 in the other. Eyesight must be correctable to 20/20 or 20/30) Any standardized procedures (landolt ring, snellen) may be utilized. No error is allowed per line of symbols.

| | | | | | | | | | | |
|-------------|----|----|----|----|-----|----|----|----|----|-----|
| Uncorrected | O. | D. | 6/ | or | 20/ | O. | S. | 6/ | or | 20/ |
| Corrected | O. | D. | 6/ | or | 20/ | O. | S. | 6/ | or | 20/ |

Corrected by eyeglasses p
 Corrected by contact lenses p
 If corrected by eyeglasses, are lenses impact resistant (ansi z. 80.1, 1979) p

2. **Visual Fields**

A visual field for the purpose of this examination is defined as a vision of 140° in each eye in the horizontal plane.

Normal p
 Abnormal p

3. **Colour Vision**

Any standardized pseudo-isochromatic plates (Ishihara, A-O, HRR, Dvorine) must be utilized. If HRR are used and if there is a deficiency, please state the degree.

If the applicant failed the plate test, name other tests used (such as Farnsworth D-15, Anomaloscope).

Pseudo-Isochromitic Plates Type _____

If failed, indicate other test used Passed p Failed p

If deficiency on HRR, state degree Mild p Medium p Strong p

Reason for colour failure Protan p Anopia p Deutan p

Tritan p Anomalia p

4. **Binocular Vision**

Yes p No p

5. **Corrective Surgery**

Yes p Type _____ Date(s) _____ No p

6. **Comments**

State if there is any problem, acute or chronic, with the function of the eyes and their adnexae. State any other positive findings.

7. **Declaration**

I declare that the statements made to ophthalmologist/optometrist are complete and correct to the best of my knowledge and that I have not withheld any relevant information or made any misleading statements. I also recognize that the expense of this examination is my responsibility.

Signature: _____ Date: _____

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|------------------------------------|---------------------|-----------------------|
| Ophthalmologist/Optometrist | | License Number |
| Address | City or Town | Postal Code |
| Signature | | Date |