# Juvi 200dpi IDJC POST-CERTIFIED EMPLOYEE VISION EXAM REPORT

Employee’s Full Name PCN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Provided by HR)

**To the employee:** This exam must be performed by an optometrist, *ophthalmologist*, or a physician with the necessary equipment to conduct the examination below. **After the optometrist, ophthalmologist, or physician completes this form, return it to Human Resources at IDJC Headquarters.**

**To the examining physician/optometrist/ophthalmologist:**  The above-named employee has been selected for an Idaho Department of Juvenile Corrections POST-certified position and will participate in a training academy or is currently employed in a POST-certified position and requires medical certification to perform the required duties. A thorough eye/vision examination is required prior to acceptance into the Idaho Department of Juvenile Corrections POST Academy and every five years thereafter.

An employee in a POST-certified position *must* meet the following minimum vision requirements:

|  |  |  |
| --- | --- | --- |
| **Vision Requirement** | **List test result or any impairment** | **Meets Minimum** |
| The employee shall have uncorrected vision in each eye of no weaker than 20/200, with the strong eye corrected to 20/30 and the weaker eye corrected to 20/60.An employee who wears contact lenses is exempt from the uncorrected vision of 20/200, but shall have the strong eye corrected to 20/30 and the weaker eye corrected to 20/60.A full eye examination shall be administered by an optometrist or ophthalmologist to any employee who wears glasses whose uncorrected vision in either eye is 20/150 or weaker. | **Employee wears**  no corrective lenses glasses only glasses & contact lenses contact lenses only**Uncorrected** Right Eye 20/ Left Eye 20/ **Corrected** Right Eye 20/ Left Eye 20/  | Yes | No |

**AN APPLICANT/EMPLOYEE WHO HAS UNCORRECTED VISION OF 20/200 OR WEAKER MUST WEAR CONTACT LENSES ON DUTY OR REQUEST A WAIVER TO WEAR GLASSES.**

**PHYSICIAN/OPTOMETRIST/OPHTHALMOLOGIST STATEMENT AFTER EXAMINATION:**

**Please initial the appropriate statement**

\_\_\_\_\_\_The employee **MEETS** the minimum vision standards to perform the full duties required of an employee in a POST-certified position.

\_\_\_\_\_\_ The employee **DOES NOT CURRENTLY MEET** the minimum vision standards to perform the full duties required of an employee in a POST-certified position, but may with surgery or use of medical aid (glasses, contacts, etc.). See details below.

\_\_\_\_\_\_ The employee **DOES NOT MEET** *(and is not likely to meet*) the minimum vision standards for the following reasons:

**Printed Name of Examiner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Examiner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IMPORTANT! Type or stamp physician’s name, address, and telephone number below:**

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**PLEASE COMPLETE ALL ITEMS—INCOMPLETE FORMS WILL BE RETURNED**