SAANICH POLICE DEPARTMENT
VISION EXAMINATION OF APPLICANT

Surname:	**Given Name(s):**	**Date of Birth:**
Address:		**Postal Code:**

1. **VISUAL ACUITY - SNELLEN TEST**

UNCORRECTED	O.D. **6**/ OR **20**/	O.S. **6**/ OR **20**/	BOTH **6**/ OR **20**/
CORRECTED	O.D. **6**/ OR **20**/	O.S. **6**/ OR **20**/	BOTH **6**/ OR **20**/

☐ Corrected by eyeglasses ☐ Corrected by contact lenses

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 and the absence of Scotoma.
☐ Normal ☐ Abnormal

3. **COLOUR VISION** - Any standardized pseudo-isochromatic plates (Ishihara) must be utilized. Testing is to be done without the candidate using any colour correcting aids, such as coloured contact lenses.

TEST USED: ☐ Ishihara ☐ Farnsworth D-15 ☐ **PASSED** ☐ **FAILED**

4. **NORMAL BINOCULAR VISION**: ☐ YES ☐ **NO**

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

_____

_____

_____

6. **DECLARATION:** I declare that the statements made to the doctor, are complete and correct to the best of my knowledge and that I have not withheld any relevant information or made any misleading statements.

_____
Signature (in the presence of the examiner)

Name of Physician, Ophthalmologist or Optometrist: (or STAMP) _____

Business Address: _____ Postal Code: _____

Telephone: _____

_____ _____
Signature Date (Y/M/D)

LASER EYE SURGERY REPORT

Surname: _____ Given Names: _____

Address: _____ Postal Code: _____

Telephone: _____ Date of Birth: _____

Re: Laser Eye Surgery - 1 Month Report

This report **must** be completed by the surgeon who performed the laser eye surgery or an Ophthalmologist/eye surgeon at least 1 month post laser eye surgery.

Applicant - please read the following and sign in the presence of the examiner:

I DECLARE THAT:

1. The statements I have made to my ophthalmologist/eye surgeon are complete and correct to the best of my knowledge.
2. I have not withheld any relevant information from my ophthalmologist/eye surgeon.
3. I have not made any misleading statements to my ophthalmologist/eye surgeon.
4. I understand that making any false or misleading statements to my ophthalmologist/eye surgeon will invalidate his/her opinion with respect to my physical fitness to serve as a Regular Member of the Saanich Police Department. As a result, I may not meet the physical requirements of a Regular Member of the Saanich Police Department and I will be subject to administrative discharge.
5. The cost of this examination and report and any subsequent reports prepared by an ophthalmologist/eye surgeon is my responsibility.

_____ _____

Signature of Applicant Date (Y/M/D)

Laser Eye Surgery Report
To be completed by the Ophthalmologist/eye surgeon
(Please indicate yes or no by each symptom)

The applicant has advised that he/she suffers from: "Halos"_____ "Starbursts"_____

Difficulty with night vision _____ Difficulty with contrast sensitivity _____

The ophthalmologist/eye surgeon states that the applicant has: Stable vision _____

No increased risk, in relation to a "normal" eye, for damage to the eye upon physical confrontation _____

Ophthalmologist/Optometrist **Date of Eye Surgery** _____

Name: _____ License No.: _____

Business Address: _____ Postal Code: _____

Telephone: _____

_____ _____

Signature Date (Y/M/D)