Date: [Date]

To: [Employer Name/Company Name]
Attention: [Safety Department/Human Resources]

Subject: Vision Clearance for Return to Commercial Driving Duties

Patient Name: [Driver's Full Name]
Date of Birth: [DOB]
Driver's License Number: [License Number]

To Whom It May Concern,

I have performed a comprehensive vision examination on the above-named individual on [Date of Exam]. This evaluation was conducted to determine the patient's visual fitness to operate a commercial motor vehicle (CMV) following [Nature of incident/condition, e.g., eye surgery or temporary medical leave].

I certify that the patient meets the following vision standards required for commercial driving:

- Distant visual acuity of at least 20/40 (Snellen) in each eye, with or without corrective lenses.
- Field of vision of at least 70 degrees in the horizontal meridian in each eye.
- The ability to recognize the colors of traffic signals and devices showing standard red, green, and amber.

Status:
[ ] Cleared for full duty without restrictions.
[ ] Cleared for full duty with the requirement of corrective lenses.
[ ] Not cleared for commercial driving duties at this time.

If you require further clinical information or have questions regarding these results, please contact my office at [Phone Number].

Sincerely,

[Signature of Medical Examiner/Optometrist/Ophthalmologist]
Printed Name: [Full Name]
Medical Title/Credentials: [e.g., OD or MD]
License Number: [State License Number]
Clinic Name: [Clinic/Facility Name]
Address: [Clinic Address]