



Civil Service & Personnel  
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## Visual Acuity Statement – City of Hamilton Firefighter Applicants

**VISION CARE PHYSICIAN: IN ORDER TO DETERMINE FIREFIGHTER VISION STANDARD ELIGIBILITY, IT IS NECESSARY THAT YOU PROVIDE THE FOLLOWING INFORMATION. WE ASK THAT YOU PROMPTLY RETURN THIS FORM TO THE CIVIL SERVICE AND PERSONNEL DEPARTMENT. THANK YOU FOR YOUR COOPERATION.**

**Applicant/Patient's Name:** \_\_\_\_\_

- **Corrected Vision: Right** \_\_\_\_\_ **Left** \_\_\_\_\_ **Both (OU)** \_\_\_\_\_
- **Uncorrected Vision: Right** \_\_\_\_\_ **Left** \_\_\_\_\_ **Both (OU)** \_\_\_\_\_
- **Vision is corrected with**  **contact lenses or**  **spectacles (please check one)**
- **If vision is corrected with contact lenses, has the patient been a successful long-term wearer of contact lenses for six (6) months WITHOUT a problem?**  **Yes**  **No**

**If no, please explain:** \_\_\_\_\_

PATIENTS OF LASIK OR OTHER VISION CORRECTION SURGERIES NEED THE FOLLOWING INFORMATION:

- Date of Surgery \_\_\_\_\_
- Is Correction Needed:  YES  NO
- Corrected Vision \_\_\_\_\_
- Uncorrected Vision \_\_\_\_\_

### **PHYSICIAN'S CERTIFICATION:**

This visual acuity data is valid until (provide exp. date here): \_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Phone Number: \_\_\_\_\_

Physician Fax Number: \_\_\_\_\_