



# Vision Examination of Applicant

Applicant ID
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## Applicant Information

<b>To be completed by the applicant</b>			
Surname	Given Names		Date of Birth (yyyy-mm-dd)
Address		Postal Code (A9A 9A9)	Date of Examination (yyyy-mm-dd)

## Vision Standard

RCMP Vision Standards

- Visual Acuity**
  - Corrected vision (with glasses or contacts): Visual acuity must be at least 6/6 (20/20) in one eye and 6/9 (20/30) in the other.
  - Uncorrected vision (without glasses or contacts): Visual acuity must be at least 6/18 (20/60) in each eye **or** 6/12 (20/40) in one eye and at least 6/30 (20/100) in the other eye.
- Field of Vision**

Must be at least 150 degrees continuous along the horizontal meridian and 20 degrees continuous above and below fixation, with both eyes open and examined together.
- Depth Perception**

Normal stereo vision (use of both eyes to judge distances) must be present. Stereo acuity must be 100 seconds of arc or less on the TITMUS Test or equivalent.
- Colour Vision Testing**

Using any standardized Pseudo-Isochromic plates (Ishihara, A-O, HRR, Dvorine). If you correctly identify all patterns presented in such tests, your colour-vision will be considered normal.

## Visual Examination

**To be completed by the Ophthalmologist or Optometrist**

### Visual Acuity

Meets Standards?  
 Yes       No

Any standardized procedures (Landoit Ring, Snellen) may be utilized. No error is allowed per line of symbols.

Uncorrected Right Eye (6/ or 20/):	Uncorrected Left Eye (6/ or 20/):
Corrected Right Eye (6/ or 20/):	Corrected Left Eye (6/ or 20/):

Corrected by:  
 Eyeglasses       Contact Lenses

### Visual Fields

Meets Standards?  
 Yes       No

A normal visual field for the purpose of this examination is defined as a vision of 150° continuous in the horizontal meridian and 20° continuous above and below fixation with both eyes open and examined together.

Normal       Abnormal

### Colour Vision

Meets Standards?  
 Yes       No

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

a) Indicate test used  
 Ishihara       A-O       HRR       Dvorine

Result of standardized pseudo-isochromatic plates test  
 Passed       Failed. Re-test using Farnsworth D-15 and **attach the results.**

b) Result of Farnsworth D-15 test (if the applicant failed the plate test). **Attach the results.**  
 Passed       Failed

# Vision Examination of Applicant

Protected B  
once completed

Applicant ID

## Binocular Vision

Meets Standards?

Yes  No

Result of binocular vision expressed in seconds of arc

Test Used (must be TITMUS or equivalent)

## Ocular Pressures

Ocular pressure normal?

Yes  No. If no, please provide the ocular pressure for both eyes

Right Eye Ocular Pressure

Left Eye Ocular Pressure

## Past History of Ocular Disease and / or Surgery

To be completed by Ophthalmologist or Optometrist

Has the applicant been treated for ocular disease?

Yes  No

Has the applicant had surgery for ocular disease?

Yes  No

If the applicant had surgery for ocular disease, please identify the type of surgery:

LASIK  PRK  Other specify:

Date of Surgery (yyyy-mm-dd):

At 1 month post-op, any history of:

Halos  Starbursts  Night Vision Difficulties  Contrast Sensitivity Difficulties

Is the applicant's vision now stable?

Yes  No

Is there currently any increased risk, relative to "normal" eyes, for damage to the eyes upon physical confrontation?

Yes  No

Specify any other acute or chronic problems with the function of the eyes or adnexae, if applicable.

## Declaration and Consent

I, (applicant), declare that the statements made to the 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 consent that this information be provided to the Royal Canadian Mounted Police for pre-selection purposes.

The cost of this examination and report and / or corneal laser surgery or any subsequent reports prepared by the ophthalmologist or optometrist is my responsibility.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date (yyyy-mm-dd)

## Physician Information

To be completed by the Ophthalmologist or Optometrist

Name of Physician

Specialty

Ophthalmologist  Optometrist

License Number

Business Address

Telephone Number

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date (yyyy-mm-dd)