Department of Transport

Western Australian Recreational Skipper's Ticket

Eyesight Declaration

When blank, this form is classed as **OFFICIAL**, when filled out, this form is classed as **OFFICIAL-SENSITIVE.**

Applicant's Details

Surname: _____ First Name: _____ Other Names: _____

Sex: _____ Date of Birth: _____

Residential Street Number/Lot: _____ Residential Street Name: _____

Suburb: _____ Postcode: _____

Telephone Home: _____ Work: _____ Mobile: _____

Optometrist's / Medical Practitioner's / Registered Nurse's Declaration

This examination is to assess and to determine whether the above named applicant's eyesight meets a minimum vision standard of at least 6/12, in at least one eye.

Results of Examination

Letter Test Without using any aids to vision	Right Eye	Left Eye
	6	6

Letter Test With aids to vision (If applicable)	Right Eye	Left Eye
	6	6

I _____ of _____
(Name of Optometrist / Medical Practitioner / Registered Nurse) *(Practice name and address)*

_____ Work Telephone: _____,

being a registered Optometrist / Medical Practitioner / Registered Nurse, have on this day examined and certify the above named applicant:

☐ HAS NOT met the minimum vision standard of at least 6/12, in at least one eye; or

☐ HAS met the minimum vision standard of at least 6/12, in at least one eye **with aids to vision**; or

☐ HAS met the minimum vision standard of at least 6/12, in at least one eye **without aids to vision**.

Signed: _____ Date: _____ / _____ / _____
(Optometrist / Medical Practitioner / Registered Nurse)