# *Vision test certificate*

***for operation of vehicles in the airside operating area of Frankfurt Airport***

## *1. Name and address of physician*

| |
|---|
| Last name |
| First name |
| Street address |
| Postal code, city/town |

## *2. Participant personal details*

| | |
|---|---|
| Last name | Date of birth |
| First name | |
| Street address | |
| Postal code, city/town | |

## *3. Test performed on (date)* _____

☐ With corrective lenses ☐ Without corrective lenses

| | Passed | Not passed | | Passed | Not passed |
|---|---|---|---|---|---|
| **Daytime visual acuity** | ☐ | ☐ | **Color vision** | ☐ | ☐ |
| **Stereoscopic vision** | ☐ | ☐ | **Mesopic vision** | ☐ | ☐ |
| **Glare sensitivity** | ☐ | ☐ | | | |

## *4. Assessment*

☐ The vision requirements are met.

☐ Not fit to operate a vehicle in the airside operating area of Frankfurt Airport

☐ The vision requirements are met if the following conditions are fulfilled:

☐ With suitable corrective lenses ☐ No passenger transport

☐ No situations with increased requirements for spatial vision

☐ No forklift ☐ No equipment used to drive up to aircraft

The identity of the individual tested was checked using his/her government-issued photo ID or passport and is confirmed with signature.

**The vision test certificate must have been issued within the 12 months preceding the time when it is submitted.**

| | |
|---|---|
| Place, date | Stamp and signature |