



# STATE OF NEW YORK DEPARTMENT OF MOTOR VEHICLES

6 EMPIRE STATE PLAZA, ALBANY NY 12228

## EYE TEST REPORT FOR MEDICAL REVIEW UNIT

**MAIL TO:**

Medical Review Unit, Rm. 337  
New York State  
Department of Motor Vehicles  
6 Empire State Plaza  
Albany NY 12228

**(QUESTIONNAIRE FOR PERSONS WITH CORRECTED VISION OF LESS THAN 20/40  
BUT NOT LESS THAN 20/70, OR TELESCOPIC LENS WEARERS)**

**INSTRUCTIONS:**

- This questionnaire must be completed by a physician, ophthalmologist or optometrist, and must be based on an examination performed within 60 days. **PLEASE RETURN THE COMPLETED ORIGINAL OF BOTH PAGES OF THIS FORM TO THE MEDICAL REVIEW UNIT AT THE ADDRESS SHOWN IN THE BOX ABOVE.**
- If this completed questionnaire *and all related statements* are not returned to the Medical Review Unit (*at their address above*), your license may be suspended. **YOU MUST HAVE APPROVAL FROM THE MEDICAL REVIEW UNIT BEFORE YOU CAN OBTAIN A VALID LICENSE. ALL MEMBERS OF THE LOW VISION PROGRAM ARE REQUIRED TO PROVIDE AN EVALUATION STATEMENT FROM THEIR EYE CARE PROVIDER EVERY 6 MONTHS OR ONCE A YEAR, DEPENDING UPON THE RECOMMENDATION OF THE EYE CARE PROVIDER.**

**MINIMUM STANDARD FOR INDIVIDUALS WITH CORRECTED VISION OF LESS THAN 20/40, BUT NOT LESS THAN 20/70:**

- Horizontal, binocular field of vision must be no less than 140 degrees.

**MINIMUM STANDARD FOR TELESCOPIC LENS WEARERS:**

- Must have been fitted with, trained to use, and used telescopic lenses for at least 60 days prior to filing this form. **For a first-time evaluation, telescopic lens wearers must complete the certification at the bottom of Page 2.**
- Clip-on or hand-held telescopic lenses are not acceptable
- Visual acuity (Snellen Method) through telescopic portion in either or both eyes must be **NO LESS THAN 20/40**
- Visual acuity (Snellen Method) through carrier lens in either or both eyes must be **NO LESS THAN 20/100**
- Total horizontal, binocular field of vision (no field expanders) must be **NO LESS THAN 140 DEGREES**
- Must pass road test if he/she has not taken a road test while wearing his/her telescopic lenses
- Eligible for a Class D or DJ driver license only
- Ineligible for a commercial driver license (CDL), a motorcycle license or a moped license.

**PATIENT — COMPLETE THIS SECTION**

***Please Print or Type***

Name \_\_\_\_\_  
(Last) (First) (M.I.)

Address \_\_\_\_\_  
(Number and Street) (Apt. No.)

\_\_\_\_\_  
(City) (State) (Zip Code)

New York State Client ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

**PRACTITIONER — COMPLETE THIS SECTION**

Patient's Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) Date of Birth \_\_\_\_\_ (Month/Day/Year)

Date of Examination \_\_\_\_\_ (Month/Day/Year) (must be within 60 days) Check One:  Initial Evaluation  Re-evaluation

1. Visual Acuity (Snellen Method) NOTE: Please check the appropriate box to identify how visual acuity was achieved, then give the visual acuity.

- With corrective lenses Right eye 20/ \_\_\_\_\_ and/or left eye 20/ \_\_\_\_\_ Both 20/ \_\_\_\_\_
- Without corrective lenses
- With telescopic lenses only Through telescopic lenses right eye 20/ \_\_\_\_\_ and/or left eye 20/ \_\_\_\_\_  
Through carrier lenses right eye 20/ \_\_\_\_\_ and/or left eye 20/ \_\_\_\_\_

2. If telescopic lenses are used, on what date did patient receive them? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3. Does the patient meet or exceed the minimum acceptable horizontal, binocular field of vision of **140 degrees**?  Yes  No

NOTE: The test object size for determining horizontal, binocular field of vision must be either a white 3 mm size test object at a one-half meter distance, or a white 6mm size test object at a one meter distance, or the equivalent angular size for any test distance.

4. If telescopic lenses, did the patient achieve his/her horizontal, binocular field of vision with the use of field expanders?  Yes  No

5. What medical condition(s) caused the present loss of the patient's visual acuity? \_\_\_\_\_  
\_\_\_\_\_

6. Patient should be re-evaluated every .....  6 Months  Year

7. Is this condition stable at this time? .....  Yes  No

8. Check restriction(s) you recommend:  Day Driving Only  Full-View Mirror  No Limited Access Roads  None

9. In your opinion, would the patient's condition interfere with the safe operation of a motor vehicle? .....  Yes  No

If "Yes", please explain in the space provided, or attach an explanation on your letterhead \_\_\_\_\_  
\_\_\_\_\_

**The above information is true, complete and best reflects my professional judgement.**

➡ \_\_\_\_\_ (Practitioner's Signature) \_\_\_\_\_ (Date)

\_\_\_\_\_ (Practitioner's Name — please print) \_\_\_\_\_ (Certificate or License Number)

\_\_\_\_\_ (Address) \_\_\_\_\_ (Telephone Number)

**TELESCOPIC LENS WEARERS MUST COMPLETE THIS CERTIFICATION ONLY FOR A FIRST-TIME EVALUATION**

I certify that I have successfully completed the minimum training requirements for telescopic lens wearers as outlined in Part 5 of the Commissioner's Regulations, and that I received the training from:

\_\_\_\_\_ (Name of Trainer) \_\_\_\_\_ (Telephone Number)

\_\_\_\_\_ (Address of Trainer)

➡ \_\_\_\_\_ (Signature of Patient) \_\_\_\_\_ (Date Training Completed)