MV-619 (10/11)

New York State Department of Motor Vehicles

EYE TEST REPORT

TO THE HEALTH CARE PROFESSIONAL:

This form should be used only for patients who are able to achieve a minimum Snellen Test score of 20/40 with one or both eyes, with or without the use of corrective lenses. Please refer to the "NOTE" at the bottom of this page.

TO THE DRIVER LICENSE CUSTOMER:

After your health care professional completes this report, take the report to any Motor Vehicles office when applying for a driver license or when renewing a driver license. To avoid a trip to DMV, mail this completed report with your license renewal application (MV-2) or use it when renewing your license at the DMV web page at: www.dmv.ny.gov/licrenew.

INSTRUCTIONS

1. In most situations, this report is valid for 12 months from the date of examination. However, based on the results of the test and on the health care professional's assessment of the patient's visual health, the person who administers the test can specify that this report be valid only for 6 months from the date of the examination. The appropriate box in number 11 must be checked.
2. Eye test examinations may be conducted only by a licensed physician, ophthalmologist, optometrist, nurse practitioner, physician's assistant, optician or registered nurse.
3. PRINT in ink or TYPE all information below (*except for signatures).*
4. Be sure to enter the patient's name exactly as it appears on the driver license.
5. Have the patient sign his/her full name in box number 8.
6. Sign your name in full, and provide your professional license number, in box number 12.
7. Give this report to the patient. Do not mail this report.

1. Patient's Last Name	First	M.I.	2. Date of Birth *(Mo./Day/Yr.)* / /	3. Sex ☐ M ☐ F
4. Patient's Address (Number and Street)				Apt. #
City			State	Zip Code
5. Best Vision Test Score (Snellen) with or without corrective lenses. Right	Left	Both	6. Date of Examination *(Mo./Day/Yr.)* / /	
7. Did the patient wear corrective lenses to achieve a Snellen Test score of 20/40 with one or both eyes? ☐ YES ☐ NO				
8. Patient's Signature (Sign Name in Full) Sign Here _____				

I have examined the patient described above, and have accurately reported my findings from that examination on this form.

9. Name and Title of Examiner		
10. Examiner's Address (Number and Street)		
City	State	Zip Code
11. This report is valid for up to (check one) ☐ 12 months ☐ 6 months from the date of examination.		
12. Examiner's Signature (Sign Name in Full) Sign Here _____		Professional License. No. _____

NOTE: For patients whose best corrected vision is less than 20/40 but not less than 20/70, and for patients who wear telescopic lenses, complete form MV-80L and mail it to the address on that form. The MV-80L can be downloaded from the DMV website at www.dmv.ny.gov/forms/mv80L.pdf or by calling:

- **Metropolitan New York City**
  - From the **212, 347, 646, 718, 917** or **929** area codes: **(212) 645-5550** or **(718) 966-6155**
- From the **516, 631, 845, 914** area codes:**(718) 477-4820**
- From **Upstate New York (all other area codes) (518) 486-9786**
- From **out of New York State: (518) 473-5595**
- **TDD: 1-800-368-1186 from anywhere in New York**

www.dmv.ny.gov