NEW YORK STATE OF OPPORTUNITY. Department of Motor Vehicles

VISION TEST REPORT

dmv.ny.gov

PATIENT INSTRUCTIONS:

You may renew online, by mail, or in person at your DMV office.

Renewal online or by mail:

a. Find a provider in DMV's Vision Registry at dmv.ny.gov/vision-registry-locator. If one of these providers completes your required vision test, you do not need this form to renew your driver license.

b. If your provider is not enrolled in DMV's Vision Registry, this report must be completed and used when renewing your license at dmv.ny.gov or by mail.

Renewal at a DMV office:

a. For no additional charge, your vision test can be completed at a DMV office.

b. DMV staff are trained to administer the eye test.

PROVIDER INSTRUCTIONS:

a. **This form should be used only for patients who have a minimum Snellen Test score of 20/40 with one or both eyes, with or without corrective lenses.** 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 (dmv.ny.gov/forms) and mail it to the address on that form.

b. ONLY a licensed physician, physician assistant, registered nurse, nurse practitioner, optician, optometrist, ophthalmologist, or supervised staff of any of these providers can complete the MV-619.
If a client renews their license at a DMV office, DMV staff are trained to administer the eye test.

c. PRINT in ink or TYPE all information below except signature.

d. Do not mail this report. Give it to the patient.

e. To enroll in DMV's Vision Registry, please visit dmv.ny.gov/visionprovide.htm. It's simple, easy and free!

1. Patient's Name (exactly as it appears on the patient's driver license) Last First MI	2. Date of Birth (MM/DD/YY) / /	3. Sex ☐ M ☐ F
4. Patient's Street Address Apt. #		
City State (If in U.S.) Country Zip Code	5. Date of Examination (MM/DD/YY) / /	
6. Did the patient achieve a Snellen Test score of 20/40 or better with one or both eyes? ☐ YES ☐ NO If NO, complete form MV-80L		
7. Did the patient wear corrective lenses during the test? ☐ YES ☐ NO		
8. Name and Title of Provider		
9. Provider's Street Address		
City State (If in U.S.) Country Zip Code		
10. This report is valid for up to ☐ 12 months ☐ 6 months from the date of examination.		
11. *I have examined the patient described above, and have accurately reported my findings from that examination on this form.* Provider's Signature (Sign name in Full) X _____	12. Professional License No. _____	