# NEW YORK STATE OF OPPORTUNITY 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	2. Date of Birth (MM/DD/YY) 3. Sex
4. Patient's Street Address	Apt. #
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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?	
8. Name and Title of Provider	-
9. Provider's Street Address	7000
City State (If in U.S.) Country	Zip Code
<u></u>	<b>~</b>
10. This report is valid for up to 12 months 6 months from the date of examination	on.
11. I have examined the patient described above, and have accurately reported my findings from that examination on this form.	s 12. Professional License No.
Provider's Signature	
(Sign name in Full) X	