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 _____ Date of Birth _____
(Last) (First) (Month/Day/Year)

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

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)