



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!

Form with fields for: 1. Patient's Name (Last, First, MI), 2. Date of Birth (MM/DD/YY), 3. Sex (M, F), 4. Patient's Street Address, Apt. #, City, State, 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, 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, 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), Sign Here X, 12. Professional License No.



Section 375(12-a)(b) of the Vehicle and Traffic Law provides that the front windshield and side windows on both sides of any eligible vehicle that is operated in New York State must allow at least 70% of any light to pass through. The rear window may allow less than 70% of any light to pass through if the vehicle has mirrors on both sides that can be adjusted so the driver has a clear view of the road and traffic conditions behind the vehicle. The rear side windows of any station wagon, sedan, hardtop, coupe, hatchback or convertible must also allow 70% of any light to pass through. A vehicle falls into one of these categories if it is labeled "Passenger Car" on the Federal ID label found on the left front door panel.

The law provides an exemption for any person who, for medical reasons, must be shielded from direct sunlight. The person who requests an exemption may be either the driver or someone who is a regular passenger in the vehicle.

NYS Health Department regulations specify that only certain medical conditions can be used to justify an exemption from the limits on light transmittance. A list of these conditions is on page 2.

INSTRUCTIONS:

To request a medical exemption, send the following items to the address at the bottom of this page:

- 1. This completed application:
- Page 1 is to be completed by the requestor
- Page 2 must be completed by a physician, physician assistant or nurse practitioner
2. A photocopy of each NYS vehicle registration

*Note: Based on the medical information submitted, our reviewer may ask for further medical details.

Provide the following information as it appears on the vehicle registration.

Form with fields: Last Name, First, M.I., Address (Number and Street), Apt. #, City, State, Zip Code

If a medical exemption is requested for someone other than the registered owner of the vehicle, please provide the following information about that person.

Form with fields: Last Name, First, M.I., Address (Number and Street), Apt. #, City, State, Zip Code

I certify and affirm that all information presented in this form is true and correct, that any documents, including supporting documentation, that I have presented to DMV are true, accurate and genuine. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal offense.

Signature of Vehicle Registrant X _____ Date _____ (Sign Name in Full)

Return this application to: Department of Motor Vehicles, Driver Regulation Bureau, Medical Review Unit, 6 Empire State Plaza, Room 337, Albany NY 12228

PHYSICIAN'S STATEMENT FOR TINTED WINDOW EXEMPTION

This side must be completed by your physician/physician assistant/nurse practitioner.

PLEASE PRINT CLEARLY

Patient's Last Name	First Name	M.I.
Date of Birth (Month/Day/Year) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	

1. Examination Date / / (Must be within one year from the date this form is submitted to the Department of Motor Vehicles.)

2. The following medical conditions, when their existence is certified by a physician, physician assistant or nurse practitioner, justify granting an exemption from the limits on light transmittance found in Vehicle and Traffic Law, section 375(12-a)(b), provided that personal protective measures such as sun protective clothing, sunscreen, eye protective devices or clear UV-protective window films, do not offer adequate protection. Check the medical condition that applies to the above-named patient:
 - albinism
 - chronic actinic dermatitis/actinic reticuloid
 - dermatomyositis
 - lupus erythematosus
 - porphyria
 - xeroderma (pigmentosa) pigmentosum
 - severe drug photosensitivity, provided that the course of treatment causing the photosensitivity is expected to be of prolonged duration
 - photophobia associated with an ophthalmic or neurological disorder
 - any other condition or disorder causing severe photosensitivity in which the individual is required for medical reasons to be shielded from the direct rays of the sun. The medical condition of _____ warrants a tinted window exemption.

Physician/Physician Assistant/Nurse Practitioner's Name (Please print in full)		<input type="checkbox"/> Physician <input type="checkbox"/> Physician's Assistant <input type="checkbox"/> Nurse Practitioner
Physician/Physician Assistant/Nurse Practitioner's Mailing Address (Include number and street)		
City	State <input type="text"/>	Zip Code <input type="text"/>
Telephone Number (area code) ()		
Based on my examination, tinted windows are necessary for my patient's health <input type="checkbox"/> Yes <input type="checkbox"/> No	Certificate or Professional License Number <input type="text"/>	State Where Licensed <input type="text"/>
I certify and affirm that all information presented in this form is true and correct, that any documents, including supporting documentation, that I have presented to DMV are true, accurate and genuine. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal offense.		
Physician/Physician Assistant/Nurse Practitioner's Signature		Date (Month/Day/Year) / /