NEW YORK STATE OF OPPORTUNITY. Department of Motor Vehicles

# EYE TEST REPORT FOR MEDICAL REVIEW UNIT

Medical Review Unit, Room 337
6 Empire State Plaza, Albany, NY 12228
dmv.ny.gov

## LOW VISION PROGRAM - FOR PERSONS WITH CORRECTED VISION OF LESS THAN 20/40 BUT NOT LESS THAN 20/70, OR TELESCOPIC LENS WEARERS

***INSTRUCTIONS:***

1. If this completed form is not returned to the Medical Review Unit, you may not renew your license and you may be suspended. **DO NOT GO INTO A DMV OFFICE UNTIL YOU HAVE SUBMITTED YOUR COMPLETED MV-80L TO THE MEDICAL REVIEW UNIT AT THE ADDRESS ABOVE AND HAVE RECEIVED A RESPONSE LETTER IN THE MAIL FROM THEM.**

2. The MV-80L must be completed by a physician, ophthalmologist or optometrist, and must be based on an examination performed within 60 days. **PLEASE RETURN BOTH PAGES OF THE COMPLETED FORM TO THE MEDICAL REVIEW UNIT AT THE ABOVE ADDRESS OR FAX IT TO (518) 402-2991.**

3. Please note, if you are currently in the Low Vision Program, you do not need to submit form MV-80L. The Medical Review Periodic Eye Test form MV-80L.1 will be mailed to you every six or twelve months based on your eye care provider's recommendation. If there are no changes or your license is not due to expire within the next year, you have satisfied the requirements and will not receive anything in the mail from us.

**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**

Name _____

Address _____

_____

Sex ☐ M ☐ F ☐ X

New York State Client ID # _____ Date of Birth _____

## 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
☐ Without corrective lenses
☐ With telescopic lenses only

Right eye 20/_____ and/or left eye 20/_____ Both 20/_____

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.**

**X** _____ _____
(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:

**X** _____ ( )
(Name of Trainer) (Telephone Number)

_____
(Address of Trainer)

_____ _____
(Signature of Patient) (Date Training Completed)



reset/clear