APPLICATION FOR TINTED WINDOW EXEMPTION



dmv.ny.gov

Section 375(12-a)(b) of the Vehicle and Traffic Law provides that the <u>front windshield and side windows</u> 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 <u>rear</u> 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 <u>rear side windows</u> 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, <u>for medical reasons</u>, 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:

Last Name

Address (Number and Street)

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

If this form is not filled out in its entirety or you did not include a copy of each NYS vehicle registration, the application will not be processed.

МΙ

Driver License ID #

Apt. #

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

First

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

City	State	Zip Gode	Phone Number	
If a medical exemption is required following information about that		nan the registered owne	er of the vehicle,	, please provide the
Last Name	First	M.I.	Driver License ID #	ŧ
Address (Number and Street)				Apt. #
City	State	Zip Code	Phone Number	
I certify and affirm that all infor	mation presented in this form	n is true and correct, tha	t 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.

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) / /						
Examination Date/ / / (Modern Vehicles.) Department of Motor Vehicles.)	fust be within or	ne year from the date	this form is su	bmitted to the		
 The following medical conditions, when their existe justify granting an exemption from the limits on light provided that personal protective measures such as sur window films, do not offer adequate protection. Chemical albinism chronic actinic dermatitis/actinic reticuloid 	ht transmittance n protective cloth	found in Vehicle and ing, sunscreen, eye pro	Traffic Law, so tective devices	ection 375(12-a)(b), s or clear UV-protective		
dermatomyositis						
☐ lupus erythematosus						
porphyria						
xeroderma (pigmentosa) pigmentosum						
severe drug photosensitivity, provided that the prolonged duration	e course of treatn	nent causing the phot	osensitivity is	expected to be of		
photophobia associated with an ophthalmic or	neurological dis	sorder				
any other condition or disorder causing severe	photosensitivity	in which the individu	ual is required	for medical reasons to		
be shielded from the direct rays of the sun. Th	e medical condi	tion of				
warrants a tinted window exemption.						
Physician/Physician Assistant/Nurse Practitioner's Name (Please print in full)				Physician Physician's Assistant Nurse Practitioner		
Physician/Physician Assistant/Nurse Practitioner's Mailing Address (Include no	umber and street)					
City	State	Zip Code	Telephone Number	(area code)		
ased on my examination, tinted windows enecessary for my patient's health				State Where Licensed		
I certify and affirm that all information presented in documentation, that I have presented to DMV are trupenalty of perjury and I understand that knowingly many	ie, accurate and	genuine. I make this	s certification	and affirmation under		
Physician/Physician Assistant/Nurse Practitioner's Signature]	Date (Month/Day/Year)		
				/ /		

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