

CERTIFICATE OF VISUAL EXAMINATION
TOP PORTION MUST BE COMPLETED BY APPLICANT

FAX NUMBER (801) 957-8698

UTAH DRIVER LICENSE DIVISION

PO BOX 144501
 SLC UT 84114-4501
 PHONE NUMBER (801) 965-4437
www.driverlicense.utah.gov

Last Name First Name Middle or Maiden Name Date of Birth Driver License or Driving Privilege Card Number

Street Address City State Zip Code Social Security Number / ITIN

Mailing Address City State Zip Code

If either your residential or mailing address has changed, please mark the box and print the new address above.
If you have a commercial license you will need to appear at a commercial driver license office to obtain a new license with your correct address.

By signing this form, I authorize my healthcare professional(s) to disclose specific health information regarding my physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to the Utah Driver License Division, P.O. Box 144501, Salt Lake City, Utah 84114-4501. This authorization is valid for five years or the period of time needed to fulfill its purpose, whichever comes first. I also understand that I may revoke this authorization at any time, by sending written notification to the Utah Driver License Division at the above address.

I understand that if I fail to sign this authorization my driving privilege may be affected. I understand that this information may no longer be protected in accordance with HIPPA but will be classified as a private record in accordance with GRAMA (UCA 63G-2-202). Individuals who are entitled to have a "private" record disclosed to them are limited to the subject of the record, a parent or legal guardian of an unemancipated minor or legally incapacitated individual, an individual with power of attorney or a notarized release signed by the subject of the record, or an individual with a court or legislative subpoena.

Applicant's Signature X: _____ Date _____

***** Form will not be processed without signature*****
(Visual Acuity Report and restrictions to be filled out by Health Care Professional.)

Visual Acuity	Are lenses required while driving?		Visual Field 120° 60° to both right and left <u>Private and Commercial</u> CDL COLOR BLIND <input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Without Correction	With Correction	
RIGHT EYE	20/	20/	<input type="checkbox"/> YES <input type="checkbox"/> NO
LEFT EYE	20/	20/	<input type="checkbox"/> YES <input type="checkbox"/> NO
BOTH EYES	20/	20/	<input type="checkbox"/> YES <input type="checkbox"/> NO

Circle Profile Level: 1 2 3 4 5 6 7 8 9 10 Shaded areas require Medical Advisory Board review

Restrictions: Speed Area Daylight Only Accompanied by Licensed Driver

YES NO If visual fields are less than 120°, are they at least 90°, with 45° to both the right and left of fixation?
 YES NO If visual fields are less than 90°, are they at least 60°, with 30° to both the right and left of fixation?
 YES NO With regards to driving safety, does this person have any medical conditions of significance? If so, please list condition: _____

Indicate the etiology of the visual impairment: _____

How stable is the visual condition? _____

Recommended interval for examination: Standard for Profile Level Other: Specify Interval _____

I recommend this driver complete a driving skills test in an appropriate vehicle.

Date of Examination Printed Name of Health Care Professional Signature and Degree State License Number
(Current within 6 months)

Street Address City State Zip Code Telephone Fax Number

For Office Use Only: DLD Screening

Date of Examination Signature Employee Number Field Station