



Certificate of Visual Examination

Utah Driver License Division
 P.O. Box 144501
 SLC, UT 84118-4501
 Phone: (801) 965-4437 Email: dlmedical@utah.gov
 Medical Portal: dldmedical.ps.utah.gov

Fax: 801-957-8698

 Last Name First Name Middle Date of Birth Driver License Number

 Driver's Signature Date

The following portion of this form is to be completed by a vision health care professional. Fraudulent submission can result in criminal and administrative action. Medical information submitted on this form should be restricted to information that is needed in relation to public safety and driving. For more information on how to submit this form, visit dld.utah.gov. A full listing of current medical guidelines for vision can be found on our website at <https://dld.utah.gov/healthcare-providers/>

Visual Acuity	Are corrective lenses required while driving?		Is this driver's visual field 120 degrees, 60 degrees to both right and left of fixation? The standard for visual fields the same whether the driver is a CDL or private operator.
	<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

If this driver is a CDL driver, are they color blind? Yes No

*If visual fields are less than 120 degrees please answer the following two questions:
 Are the visual fields 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

<p>Vision Health Care Professional Recommend Review Time Frame</p> <p><input type="checkbox"/> Standard review time <input type="checkbox"/> Six month review time <input type="checkbox"/> One year review time <input type="checkbox"/> Upon renewal of license <input type="checkbox"/> No further review <input type="checkbox"/> Other <input type="checkbox"/> There are special considerations I would like to discuss</p>	<p>Vision Health Care Professional Recommended Restrictions</p> <p><input type="checkbox"/> Speed- posted 40 mph or less <input type="checkbox"/> Daylight only <input type="checkbox"/> Area (requires driving review) <input type="checkbox"/> Vision health care professional recommended driver review: Would require driver to complete a physical assessment, written test and driving skills test.</p>
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Is there a medical condition that is relevant to driving and public safety for this driver? If so, what medical condition _____

 How stable is this drivers visual condition? _____
 Vision health care professional comments _____

*required responses for submission in applicable scenarios. Submission will not be accepted if older than 6 months or if required medical information is missing)

 *Exam Date *Printed Name of Health Care Professional Signature Degree State License Number

 Form Signed Date *Street Address City State Zip Code Telephone