Department *of* Public Safety
Driver License Division

CERTIFICATE OF VISUAL EXAMINATION

Last Name	First Name	Middle	Date of Birth

Driver License Number	Date	Driver's Signature

The following portion of this form is to be completed by a Vision Health Care Professional (HCP). 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 and a full listing of current medical guidelines, visit our website at **dld.utah.gov/health-care-professionals.**

*Are corrective lenses required while driving? YES ☐ NO ☐

Visual Acuity	Without Correction	With Correction	Visual Field
			Is this driver's visual field 120 degrees, 60 degrees to both right and left of fixation? The standard for visual fields is the same whether the driver is a CDL or private operator.
Right eye	20/	20/	YES ☐ NO ☐
Left eye	20/	20/	YES ☐ NO ☐
Both eyes	20/	20/	YES ☐ 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 ☐

Vision Health Care Professional Recommended Review Time Frame (recommendations made by the individual's HCP supersede standardized guidelines)

☐Standard review time ☐Upon renewal of the license ☐Six-month review time ☐One-year review time ☐No further review
☐Other: _____ ☐There are special considerations I would like to discuss.

Vision Health Care Professional Recommended Restrictions

☐Speed-posted 40 mph or less ☐Daylight driving only ☐Area (requires driving review)

Vision Health Care Professional Recommended Driver Review

☐Would require the driver to complete a physical assessment, written knowledge, and driving skills test.

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 driver's 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 the required medical information is missing.)

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

*Form Signed Date	*Street Address	City	Zip Code	Telephone

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