Department *of* Public Safety
Driver License Division

INVISIBLE CONDITION REQUEST

Last Name	First Name	Middle	Date of Birth

Driver License/ID Number	Date	Applicant's Signature

I request that the Driver License Division place an invisible condition identification symbol on my record. I further request that the information be shared on the Utah Criminal Justice System for law enforcement. In accordance with UCA §53-3-207.

- I voluntarily release my medical information and waive any and all claims against the Department of Public Safety, Driver License Division, or any person who may have access to my medical information as contained in my driving record and/or any other person who may view or receive notice of my medical information by viewing my driver license or identification card.
- I am consenting to the release of the medical information listed on this form and waive any claims of privacy regarding this medical information under state or federal law.
- I understand that the inclusion of the invisible condition symbol on my driver license or identification card does not confer any legal rights or privileges to me, including but not limited to parking privileges for individuals with disabilities.
- I understand that if I have a driver license, I may be requested to complete a periodic medical or vision form in accordance with UCA §53-3-303. See the table below for the suggested category submission to complete the form.

The applicant listed above has the following invisible condition(s):

☐ Communication impediment	☐ Hearing loss	☐ Traumatic brain injury (D)
☐ Post-traumatic stress disorder (G)	☐ Drug allergy	☐ Schizophrenia (G)
☐ Blindness or visual impairment (vision)	☐ Epilepsy (E)	☐ Developmental disability (D)
☐ Autism spectrum disorder (D)	☐ Diabetes (A)	☐ Down syndrome (D)
☐ Alzheimer's disease or dementia (F)	☐ Heart condition (B)	☐ Other: _____

Health care professional comments: _____

_____

_____

☐ This patient has a driver license, and a copy of a medical or vision form has been attached and marked with the appropriate category.

By signing below, I certify that I am a health care professional as defined in UCA §53-3-207 and the individual above has the listed condition(s).

Printed Name of Health Care Professional: _____

Address (Street, City, State, Zip): _____ Phone: _____

State License Number: _____ Degree: _____ Signature: _____ Date: _____

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