Department *of* Public Safety
Driver License Division

IID REMOVAL PETITION PHYSICIAN STATEMENT

Last Name	First Name	Middle	Date of Birth

Driver License Number

The following portion of this form is to be completed by a 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 safe driving and the driver's ability to use an ignition interlock device. A full listing of current medical guidelines is available on our website at **dld.utah.gov/health-care-professionals.**

A completed Functional Ability Medical Report must accompany this form, identifying each medical category that may affect the driver, and reproducible spirometry, including graphs, conducted within the last 90 days.

List the diagnoses that prevent the driver from providing a deep lung air sample to an Ignition Interlock Device.

How long has the driver had this condition(s)?

Describe the current treatment plan of the condition(s) affecting the driver.

Is the driver's condition(s) expected to change in the next six months? YES ☐ NO ☐

How do you anticipate the condition(s) will change?

Describe the test(s) conducted demonstrating the medical condition(s) that prevent the driver from providing a deep lung air sample.

Health Care Professional:

Exam Date: Printed Name of Health Care Professional:

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

State License Number: Degree: Signature: Date:

Phone: 801.963.7325 ~ Email: dlmedical@utah.gov ~ Fax: 801.957.8698
PO Box 144501, Salt Lake City, Utah 84114-4501