Invisible Condition Request Form

Utah Driver License Division
P.O. Box 144501
SLC, UT 84114-4501
Phone: 801-963-7325 Fax: 801-957-8698 Email:dlmedical@utah.gov

First Name _____ Last Name _____

Date of Birth _____ Driver License/Identification Card Number _____

I request the Driver License Division place an invisible condition identification symbol on my record. I further request to have the information 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's license, I may be requested to complete a periodic medical or vision form in accordance with UCA §53-3-303. See table below for suggested category submission to complete form.

Applicant's Signature _____ Date _____

The individual 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:_____

Dr. Comments: _____

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

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

Printed name of HCP and degree _____ Signature _____ State license number _____

Street address _____ City _____ State _____ Zip _____ Telephone _____

Functional Ability Evaluation Medical Report

Utah Driver License Division
P.O. Box 144501
SLC, UT 84114-4501
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 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 safe driving. For more information on how to submit this form, visit dld.utah.gov. A full listing of current medical guidelines can be found on our website at https:// dld.utah.gov/healthcare-providers/

	A **Diabetes and Metabolic Conditions** ☐ Insulin-dependent	B **Cardio-vascular** ☐ Hyper-tension only	C **Pulmonary** ☐ Oxygen w/driving ☐ Inhaler only	D **Neurologic**	E **Seizures & Episodic Conditions** Date of last seizure _____	F **Learning & Memory**	G **Mental Health**	H **Alcohol & Other Drugs**	J **Musculo-skeletal or Chronic Debility**	K **Alertness or Sleep Disorder**
1										
2										
3										
4										
5										
6										
7										
8	No driving	No driving	No driving	No driving	No driving	No driving	No driving	No driving	No driving	No driving

Health Care Professional Recommend Review Time Frame

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

Health Care Professional Recommended Restrictions

- ☐ Speed- posted 40 mph or less
- ☐ Area (requires driving review)
- ☐ Supplemental oxygen while driving
- ☐ Daylight driving only
- ☐ **Health care professional recommended driver review**: Would require driver to complete a physical assessment, written test and driving skills test.

Is there a disorder or condition that is not marked that is relevant to safe driving for this driver? If so, what categories do you recommend?

_____

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)

1. *Exam Date _____ *Printed Name of Health Care Professional _____ *Signature & Degree _____ State License Number _____

*Form Signed Date _____ *Street Address _____ City _____ State _____ Zip Code _____ *Telephone _____

2. *Exam Date _____ *Printed Name of Health Care Professional _____ *Signature & Degree _____ State License Number _____

*Form Signed Date _____ *Street Address _____ City _____ State _____ Zip Code _____ Telephone _____

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? ☐No ☐Yes		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.
	Without Correction	With Correction	
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 Recommend Review Time Frame

- ☐ Standard review time
- ☐ Six month review time
- ☐ One year review time
- ☐ Upon renewal of license
- ☐ 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 only
- ☐ Area (requires driving review)
- ☐ Vision health care professional recommended driver review: Would require driver to complete a physical assessment, written test 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 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