

INSTRUCTIONS FOR APPLICANT:

- Original Application** - Please have your Health Care Provider complete ALL categories of the Functional Ability Evaluation Medical Report form (FAE).
- Renewal Application** - Please have your Health Care Provider complete the Functional Ability Evaluation Medical Report form (FAE) in the appropriate category.
- Visual Condition** - Please have your Vision Care Provider complete the accompanying Certificate of Visual Examination.

Please **DON'T FORGET TO...**

- Complete the Medical questionnaire. This **MUST** be complete in order to process your application.
- Submit a current MEC/DOT card.
- Submit completed Utah Medical Self-Certification form, signed and dated.
- Submit completed Intrastate only K restriction application.
- Submit completed Functional Ability Evaluation Medical Report form
- Submit completed Certificate of Visual Examination form, **if needed*
- Enclose your signed check or money order in the amount of \$25.00*, Payable to Department of Public Safety for your application processing fee. ***This is a non-refundable processing fee.**
- Lost enclosed Envelope? Mail to: Driver License Division, Attn: CDL Medical Program, PO Box 144501, Salt Lake City, UT 84114-4501

Once the medical information and application are processed, a decision will be made regarding your eligibility to obtain or maintain a CDL or Class D license with an Intrastate Only Waiver, based on established guidelines. **You will be notified of this decision by mail.** If you have any questions, please contact the K Program representative at (801) 965-3819

If you are approved for the K Waiver Program, your K Waiver card will be mailed to the address on your driver License record. Please insure the correct mailing address is on file.

**APPLICATION FOR INTRASTATE ONLY (K RESTRICTION)
MEDICAL WAIVER PROGRAM**

Because I do not fully meet the minimum Federal Health requirements for an unrestricted Commercial Driver License (CDL) or a Federal DOT/ MEC Medical Card, it is my desire to apply for or renew my **Utah Intrastate Only commercial driving privilege.**

I understand that this process requires me to submit medical information, and in some cases will require additional information from me or my medical provider. I also understand that no processing will begin until the entire packet has been completed and turned in along with any additional requested paperwork. This can take a minimum of 4-6 weeks to process, and sometimes longer with specialized cases, or cases needing Medical Advisory Board approval.

Note: Additional Testing May be required

Applicant Signature: _____ Date: _____

Full Name: _____ Driver License #: _____

Residential Address: _____

Mailing Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

DOB: ___/___/___ SSN: _____ Years of Commercial Driving Experience: _____

Current License: *Circle One* A B C D

License Class Applying for: *Circle One* A B C D

Type of Commercial vehicle(s) expected to operate: _____

Disqualifying Medical/Visual Condition: _____

List of Medications: _____

MEDICAL QUESTIONNAIRE MUST BE COMPLETED - Mark Yes or No to each question.

Additional information from your physician (Functional Ability Evaluation form) may be required before processing your Intrastate Waiver application, if you have, or if you have had, any of the following conditions in the last five (5) years:

- Diabetes:** YES NO Do you take insulin?
- Cardiovascular:** YES NO Do you have an uncontrolled heart condition?
 YES NO Do you have an implantable cardioverter defibrillator (ICD)?
 YES NO Have you lost consciousness or fainted in the last five years?
- Pulmonary:** YES NO Do you have a pulmonary (lung) condition?
 YES NO Is an inhaler the only medication prescribed for this condition?
 YES NO Do you use supplemental oxygen?
- Neurologic:** YES NO Do you have, or have you had a neurological condition such as: Dementia, Strokes, Alzheimer's, traumatic brain injury, Multiple Sclerosis, or Parkinson's?
- Epilepsy:** YES NO Do you have or have you had seizures in the last five years? Or,
 YES NO *Commercial Driver:* Anytime during your life?
- Learning & Memory:** YES NO Do you have learning and memory difficulties which may interfere with driving safety?
- Mental Health Conditions:** YES NO Do you have a mental health condition such as schizophrenia, severe anxiety, or severe depression?
- Alcohol & Other Drugs:** YES NO Do you use alcohol excessively, misuse prescription drugs, or use illegal drugs?
 YES NO Have you been treated for alcohol or chemical dependency, or has treatment been recommended by a medical professional?
- Vision:** YES NO Are you required to wear glasses or contact lenses for driving?
 YES NO Is your visual acuity worse than 20/40 in the better eye, even with corrective lenses?
 YES NO Do you have a degenerative or progressive eye condition?
 YES NO Have you experienced a decrease in peripheral (side) vision?
- Musculoskeletal:** YES NO Do you have loss or paralysis of all or part of a limb, or severe arthritis?
 YES NO New or Changed in the past 5 years?
 YES NO Present longer than 5 years
- Alertness or Sleep Disorders:** YES NO Do you have a condition that produces abnormal sleepiness (sleep apnea, narcolepsy, etc)?
- Other:** YES NO Are there any other health problems or use of medications which might interfere With driving ability or safety or control of a vehicle?
Please explain: _____

I, the undersigned, under penalty of perjury affirm that I am the applicant described on this application and that the information entered herein is true and correct to the best of my knowledge.

X _____ hereby affirmed _____ day of _____ 20 _____

Public Burden Statement

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. The OMB Control Number for this information collection is 2126-0006. Public reporting for this collection of information is estimated to be approximately one minute per response, including the time for reviewing instructions, gathering the data needed, and completing and reviewing the collection of information. All responses to this collection of information are mandatory. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Information Collection Clearance Officer, Federal Motor Carrier Safety Administration, MC-RRA, 1200 New Jersey Avenue, SE, Washington, D.C. 20590.



U.S. Department of Transportation
Federal Motor Carrier
Safety Administration

MEDICAL EXAMINER'S CERTIFICATE
(for Commercial Driver Medical Certification)

CMV DRIVER CERTIFICATION

I certify that I have examined (**last name**) _____ (**first name**) _____ in accordance with (please check only one):

the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply) **OR** the Federal Motor Carrier Safety Regulations (49 CFR 391.41-391.49) with any applicable State variances (which will only be valid for intrastate operations), and, with knowledge of the driving duties, I find this person is qualified, and, if applicable, only when (check all that apply)

- Wearing corrective lenses Accompanied by a waiver/exemption (specify type): _____ Driving within an exempt intracity zone (49 CFR 391.62) (Federal)
- Wearing hearing aid Accompanied by a Skill Performance Evaluation (SPE) Certificate Qualified by operation of 49 CFR 391.64 (Federal)
- Grandfathered from State requirements (State)

The information I have provided regarding this physical examination is true and complete. A complete Medical Examination Report Form, MCSA-5875, with any attachments, embodies my findings completely and correctly, and is on file in my office.

Medical Examiner's Certificate Expiration Date

MEDICAL EXAMINER INFORMATION

<p>Medical Examiner's Signature</p> <p>_____</p> <p>Medical Examiner's Name (please print or type)</p> <p>_____</p> <p>Medical Examiner's State License, Certificate, or Registration Number</p> <p>_____</p>	<p>Medical Examiner's Telephone Number</p> <p>_____</p> <p>MD Physician Assistant Advanced Practice Nurse</p> <p>DO Chiropractor Other Practitioner (specify) _____</p> <p>Issuing State</p> <p>_____</p>	<p>Date Certificate Signed</p> <p>_____</p> <p>National Registry Number</p> <p>_____</p>
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CMV DRIVER INFORMATION

<p>Driver's Signature</p> <p>_____</p> <p>Driver's Address</p> <p>Street Address: _____ City: _____ State/Province: _____ Zip Code: _____</p>	<p>Driver's License Number</p> <p>_____</p>	<p>Issuing State/Province</p> <p>_____</p>	<p>CLP/CDL Applicant/Holder</p> <p>Yes No</p>
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This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.



COMMERCIAL DRIVER LICENSE MEDICAL SELF CERTIFICATION



49 CFR Part 383.71 and U.C.A. 53-3-410.1 require all CDL holders that operate or expect to operate a commercial motor vehicle (CMV) must meet the certification requirements outlined below. Please read the following list of options to determine which medical certification applies to the type of driving you are engaged in.

For the medical certification process to be complete, this form must be submitted to the Division:

- upon the initial issuance of any CDL or CDIP ; **or**
- upon the upgrade of any CDL or CDIP; **or**
- upon the renewal of a CDL or CDIP; **or**
- upon the transfer of a CDL from another jurisdiction to Utah; **or**
- if the status indicated below changes.

Send form to: Fax # (801) 957-8633, Email dmedcert@utah.gov, or Mail to: CDL Med Cert, PO BOX 144501 -SLC, UT 84114-4501

SELF-CERTIFICATION (Check only **one** box for the category that applies to you)

- Non-Excepted Interstate (FEDERAL)** – I meet the qualification requirements under 49 CFR 391 of the Federal Motor Carrier Safety Regulations.
- Driver drives interstate or intrastate commerce and holds a Commercial Driver License (This includes drivers that are not currently operating a Commercial Motor Vehicle);
 - Must have a valid DOT card
 - Driver must be at least 21 years old

- Excepted Interstate (FEDERAL)** – I am exempt from the qualification requirements under 49 CFR Part 391 of Federal Motor Carrier Safety Regulations
- Driver currently drives interstate only under excepted transportation or operations listed in 49 CFR Part 390.3 (f)
 - School bus designed to carry more than 10 passengers including the driver;
 - Transportation performed by Federal, State or an agency of State government;
 - Occasional transportation of personal property not for compensation and not in the interest of commercial enterprise;
 - Transporting human remains, or sick or injured persons;
 - Operating fire trucks and rescue vehicles while involved in emergency and related operations;
 - Operating a vehicle designed to carry 9-15 passengers including the driver not for direct compensation;
 - A driver transporting propane for winter heating fuel or a driver responding to a pipeline emergency;
 - Transporting farm operation related machinery, supplies or custom-harvested crops; or
 - Beekeeper in the seasonal transportation of bees.
 - Driver must be at least 21 years old.

- Non-Excepted Intrastate (STATE RESTRICTED)**– I meet the qualification requirements of U.C.A. 53-3-303.5.
- Driver has a federally disqualifying medical condition;
 - Must be accompanied by a Utah Intrastate Waiver card;
 - The driver does not meet the guidelines to obtain a valid DOT Medical Card under 49 CFR part 391;
 - Must obtain a state DOT certificate marked for accompanied by a waiver/exemption;
 - Must complete any medical reports required by the Driver License Division;
 - Must obtain a K restriction on the license and may only drive intrastate commerce.

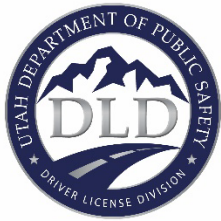
- Excepted Intrastate (STATE RESTRICTED)** – I meet the requirements of 49 CFR 391 with the exception that the driver is under 21 years of age.
- Driver is under 21 years old;
 - Has a valid DOT Medical card;
 - Must have a K restriction added to the license;
 - Not eligible to drive interstate because they are under age 21.

CERTIFICATION

I understand that it is a Class B Misdemeanor to knowingly and willfully provide false information on Medical Self Certification and may result in the disqualification of my driver license pursuant to Utah Code Ann. § 76-8-504. I hereby declare under criminal penalty of the State of Utah that the information contained in this application is true and correct.

Name _____ Date of Birth _____ DL# _____

Signature _____ Certify Date _____



Certificate of Visual Examination

Utah Driver License Division

P.O. Box 144501

SLC, UT 84114-4501

Phone: 801-957-8690 Fax: 801-957-8698 Email:dlmedical@utah.gov

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.

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? <input type="checkbox"/> No <input type="checkbox"/> Yes		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.
	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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</p> <p><input type="checkbox"/> six month review time</p> <p><input type="checkbox"/> one year review time</p> <p><input type="checkbox"/> upon renewal of license</p> <p><input type="checkbox"/> no further review</p> <p><input type="checkbox"/> Other</p> <p><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 40mph or less <input type="checkbox"/> Daylight only</p> <p><input type="checkbox"/> Area (requires driving review)</p> <p><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 _____

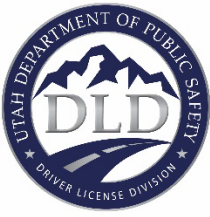
How stable is this drivers visual condition? _____

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



Functional Ability Evaluation Medical Report

Utah Driver License Division

P.O. Box 144501

SLC, UT 84114-4501

Phone: 801-957-8690 Fax: 801-957-8698 Email:dlmedical@utah.gov

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. 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 <input type="checkbox"/> Insulin dependent	B Cardio- vascular <input type="checkbox"/> Hyper- tension Only	C Pulmonary <input type="checkbox"/> Oxygen w/driving <input type="checkbox"/> 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 40mph 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

FOR USE AS AN OVERVIEW ONLY Revised 2020

This table shows, in general, the principle requirements for each level and may be used as a rough guide only. A full narrative description and table for each category are found in the **Functional Ability In Driving: Guidelines and Standards for Health Care Professionals**, which is available at a Utah Driver License Division office or online at <https://dld.utah.gov/healthcare-providers/>

	A	B	C	D	E	F	G	H	J	K
	Diabetes & Metabolic Conditions	Cardio-vascular	Pulmonary	Neurologic	Seizures & Episodic Conditions	Learning Memory Condition	Mental Health	Alcohol & Other Drugs	Musculo-skeletal or Chronic Debility	Alertness or Sleep Disorders
1	No history. No further review	No past history or fully recovered. No further review	No disease or fully recovered. No further review	No history or fully recovered. No further review	No history. No further review	No history or fully recovered. No further review	No history or no symptoms for 2 years. No further review	No history or no problems within 2 years. No further review	No history or fully recovered 1 year or more. No further review	No history or problem for 2 years. ESS <6. No further review
2	Stable with diet and/or non-insulin stimulating meds. No further review**	All AHA Class I; isolated arrhythmia, no limits, no symptoms on ordinary activity. No further review	Minimal symptoms. Sporadic use of meds. No steroids. 1 yr. review	Minimal impairment, able to control equipment in conventional manner. 5 yr. review	Single seizure but none in past 5 years, and off meds for at least 4 years. 2 yr. review	Minimal difficulty with good social and personal adjustment. No interval for review	Stable at least 1 year with or w/o meds; no psychiatric hospitalization for at least 1 year. 1 yr. review	No adverse consequences within past year. 1 yr. review	Mild residual loss of function. 5 yr. review. 2 yr. review for CDL	Problems with good self-management ESS 7-9. 2 yr. review
3	Stable on meds that stimulate insulin production. No further review**	AHA Class I; rhythm normal or stable with pace-maker for 6 months; 1 yr. min symptoms w/ strenuous activity. 1 yr. review	Symptoms on activity, intermittent steroids FVC & FEV>65% to 70% of predicted normal. 1 yr. review	Moderate impairment of dexterity. 1 yr. review	Seizure free 1 year or more, on medication, followed by additional 1yr off meds remaining seizure free. 1 yr. review	Slight impairment w/ good socialization & emotional control. 5 yr. review	Stable at least 6 months with or w/o meds; no psychiatric hospitalization for at least 6 months. 1 yr. review	No adverse consequences within past 6 months. 6 m. review	Moderate residual loss of function with or without compensatory device. 2 yr. review. Skills test on initial assessment	Mild/moderate problems, good professional management ESS 10-12. 1 yr. review
4	Stable on insulin for 1 year. 1 yr. review	AHA Class II; rhythm, stable for 3 months. 1 yr. review	Stable with O ₂ or steroids; dyspnea on exertion, no cough syncope 6 months. 1 yr. review	Moderate impairment of dexterity or decreased stamina. 1 yr. review	Seizure free 1 year or more on AED medication w/o side effects. 1 yr. review	Moderate impairment w/good socialization & emotional control. 5 yr. review. 2 yr. review for CDL. Skills test on initial assessment	Stable at least 3 months with meds; no psychiatric hospitalization for 3 months. 6 m. review	No adverse consequences within past 3 months. 3 m. review	Limited joint motion, deformity of limb or spine; amputation. 1 yr. review. Skills test on initial assessment	Moderate problems related to time of day ESS 13-15. 6 m. review. Daylight restriction
5	Stable on insulin for 6 months but < than 1 yr. 1 yr. review	AHA Class III; anticipated aggravation by unlimited driving. 1 yr. review	PO ₂ over 50, symptoms w/ordinary activity, no cough syncope 3 months. 6 m. review	Moderate neurologic impairment expected to be temporary. 6 m. review. Skills test. S.A.D.*	Seizure free 6 months to 1 yr. on AED medication w/o side effects. 6 m. review	NOT USED No definition	Stable at least 1 month with meds; no psychiatric hospitalization for 1 month. 6 m. review	No adverse consequences within past 1 month. 3 m. review	Limited joint motion, deformity of limb or spine; amputation with or w/o prosthetic device, variable weakness, pain. 1 yr. review. Skills test on initial assessment	Moderate problems related to time & circumstances ESS 13-15. 6 m. review. S.A.D.*
6	Stable on insulin for 3 months but < than 6 months. 6 month review	AHA Class III; unstable rhythm. 6 m. review. S.A.D.*	Severe dyspnea; cough syncope within 3 months. 6 m. review. S.A.D.*	NOT USED No definition	Seizure free 3 months to 6 months on AED. Level Not applicable for CDL 6 m. review.	Moderate impairment, or variable competence or control. 1 yr. review. Skills test on initial assessment. S.A.D.*	Minimal dyskinesia, or meds which minimally interfere with coordination. 6 m. review	Intermittent impairment of function, not while driving or working. 3 m. review. S.A.D.*	NOT USED No definition	NOT USED No definition
7	Special Circumstances or under evaluation									
8	Special Circumstances or under evaluation									

NO DRIVING: Driving skills test is not allowed for a safety assessment level 8

Severe, unstable, uncontrolled physical, mental or emotional impairments or conditions; with or without loss of consciousness or syncope; or severe current condition requiring hospitalization; chronic use of alcohol or drugs creating impairment or unsafe conditions; or incapacitating problems or issues that affect driving alertness, safety, coordination or ability.

* Level requires a speed, area, or daylight restriction

** Unless review is requested by Healthcare provider

Interval for review may be made longer at physician discretion

SAFETY ASSESSMENT LEVELS