Invisible Condition Request Form

Utah Driver License Division
P.O. Box 144501
SLC, UT 84114-4501
Phone: 801-957-8690 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.

_______________________________ __________
Applicant's Signature Date

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

☐ Communication impediment	☐ Hearing loss	☐ Traumatic brain injury
☐ Post traumatic stress disorder	☐ Drug allergy	☐ Schizophrenia
☐ Blindness or a visual impairment	☐ Epilepsy	☐ Developmental disability
☐ Autism spectrum disorder	☐ Diabetes	☐ Down syndrome
☐ Alzheimer's disease or dementia	☐ Heart condition	☐ 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).

_______________________________ _____________________ ____________________
Printed name of HCP and degree Signature State license number

______________________ __________ _____ __________ ____________________
Street address City State Zip code Telephone