FUNCTIONAL ABILITY EVALUATION MEDICAL REPORT

TOP PORTION MUST BE COMPLETED AND SIGNED BY APPLICANT

UTAH DRIVER LICENSE DIVISION
P O BOX 144501
SLC UT 84114-4501
Phone Number: (801) 957-8690
Fax Number: (801) 957-8698

Last Name **First Name** **Middle or Maiden Name** **Date of Birth** **Driver License or DPC #**

By signing this form, I authorize my healthcare professional(s) to disclose specific health information regarding my physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to the Utah Driver License Division.

I understand that if I fail to sign this authorization my driving privilege may be affected. I understand that this information will be classified as a private record in accordance with GRAMA (UCA 63G-2-202). Individuals who are entitled to have a "private" record disclosed to them are limited to the subject of the record, a parent or legal guardian of an unemancipated minor or legally incapacitated individual, an individual with power of attorney or a notarized release signed by the subject of the record, or an individual with a court or legislative subpoena.

APPLICANT'S SIGNATURE:_____ **Date:**_____

Form will not be processed without signature

BOTTOM PORTION TO BE COMPLETED AND SIGNED BY HEALTH CARE PROFESSIONAL

The following **safety assessment level** is for use in determining driving privileges. It is consistent with the current edition of **Functional Ability in Driving: Guidelines and Standards for Health Care Professionals. Please indicate level below with a check mark and your initials .**

Safety Assessment Level	A Diabetes & Metabolic Condition On Insulin ☐ Yes ☐ No	B Cardio-Vascular & High Blood Pressure	C Pulmonary ☐ Inhaler Only ☐ Oxygen w/Driving	D Neurologic	E Seizures or Episodic Conditions ☐ Date of last seizure _____:	F Learning Memory	G Psychiatric or Emotional Condition	H Alcohol & Other Drugs	J Musculo-skeletal/ Chronic Debility	K Alertness or Sleep Disorders	L ☐ Hearing ☐ Balance
1											
2											
3											
4											
5						N/A					
6				N/A	N/A				N/A	N/A	N/A
7					N/A						
8											

Please indicate if any of the following apply to this medical review:

☐ **Non-standard review time frame**_____

☐ Safety Assessment categories not marked are relevant and should be completed by another health care professional. Please list categories which are of concern:

_____

Recommended Restrictions:

☐ **ADD** **OR** ☐ **REMOVE**

☐ Speed-posted 40 mph or less ☐ Area

☐ Oxygen while driving ☐ Daylight only

☐ **I recommend this driver complete a driving skills test in an appropriate vehicle. (Drive test is not available for level 8)**

Date form is completed **Printed Name of Health Care Professional and Degree** **Signature & initials** **State License Number**
(Must be submitted to Driver License within 6 months)

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

Doctor's Comments_____

☐ There are special considerations I would like to discuss with a representative of the Division.

Date form is completed **Printed Name of Health Care Professional and Degree** **Signature & initials** **State License Number**
(Must be submitted to Driver License within 6 months)

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

Doctor's Comments_____

☐ There are special considerations I would like to discuss with a representative of the Division.

For more information regarding the medical program or to view current medical guidelines, please visit:
www.driverlicense.utah.gov