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

(Circle one) Current License Class: A B C D

(Circle one) License Class Needed: A B C D

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

Date:_____ Driver License #:_____

Full Name: _____

Residential Address:_____

Mailing Address:_____
(If different from residential address)

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

DOB:_____ SSN_____ Years of Commercial Driving Experience_____

Type of commercial vehicle(s) to be driven: _____

Disqualifying Medical/Visual Condition:_____

**INSTRUCTIONS FOR APPLICANT:**

☐ **Original application –** Please have your Health Care Provider complete **ALL** categories

☐ **Renewal application –** Please have your Health Care Provider complete the Functional Ability Evaluation Medical Report form (FAE) in the appropriate medical category.

☐ **Visual condition** – Please have your Vision Care Provider complete a Certificate of Visual Examination form.

**PLEASE DON'T FORGET TO….**

- ☐ **Complete the Medical Questionnaire on the reverse side. This MUST be completed in order to process your application.**
- ☐ 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 (if needed)
- ☐ Submit completed Appendix III form if disqualifying condition is diabetes.
- ☐ 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. **This is a non-refundable processing fee.**
- ☐ **Lost enclosed envelope?** Mail to: Driver License Division, Attn: Medical Program Coordinator, 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 Program Coordinator at (801) 965-3819.

**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:

☐ **Yes** ☐ **No** **A. Diabetes:** Diabetes (high blood sugar, sugar diabetes you control with diet, medication or insulin) or hypoglycemia or other metabolic condition etc., which may interfere with driving safety?

☐ **Yes** ☐ **No** **B. Cardiovascular**: Heart condition, with or without symptoms, (heart attack, heart surgery, irregular rhythm, general heart disease) within the last five years; or hypertension (high blood pressure) unable to be controlled with medication?

☐ **Yes** ☐ **No** **C. Pulmonary:** Pulmonary (lung) condition (asthma, emphysema, passing out from coughing, etc.), shortness of breath which has required treatment?

- ☐ **Yes** ☐ **No** Is an inhaler the only medication prescribed for this condition?
- ☐ **Yes** ☐ **No** Are you required to use an O2 tank while driving?

☐ **Yes** ☐ **No** **D. Neurologic:** Neurological condition (stroke, head injury, cerebral palsy, multiple sclerosis, muscular dystrophy, Parkinson's Disease, etc.) which may interfere with driving safety?

☐ **Yes** ☐ **No** **E. Epilepsy**: Epilepsy, seizures, and other episodic conditions which include any recurrent loss of consciousness or control?

- ☐ **Yes** ☐ **No Commercial:** Anytime during your life?

☐ **Yes** ☐ **No** **F. Learning and Memory:** Learning and memory difficulties observed personally or reported to you by others?

☐ **Yes** ☐ **No** **G. Psychiatric:** Psychological condition (severe anxiety, severe depression, severe behavioral mood conditions, schizophrenia, etc.), or other conditions for which hospitalization has occurred or been recommended by a physician or other mental health profession.

☐ **Yes** ☐ **No** **H. Alcohol and Drugs:** Excessive use of alcohol and/or prescription drugs, or use of any illegal drugs; or treatment or recommendation for treatment of alcohol use or chemical dependency?

☐ **Yes** ☐ **No** **I. Visual Acuity:** Do you wear glasses or contact lenses for driving?

- ☐ **Yes** ☐ **No** Is your vision 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?

☐ **Yes** ☐ **No** **J. Musculoskeletal/Chronic Debilities**: Loss or paralysis of all or part of an extremity; or onset of a general debilitating illness requiring treatment?

- ☐ **Yes** ☐ **No** New or changed in the past five (5) years?
- ☐ **Yes** ☐ **No** Present longer than five (5) years?

☐ **Yes** ☐ **No** **K. Alertness or Sleep Disorders:** Do you have a condition that produces abnormal sleepiness (sleep apnea, narcolepsy, etc)?

☐ **Yes** ☐ **No** **L. Hearing Impairment**

☐ **Yes** ☐ **No** **Balance (ENT Problems)**: Have you experienced any sudden vertigo (Meniere's Disease) or infection of the inner ear (vestibular neuronitis or labyrinthitis) which might interfere with driving ability and safety?

☐ **Yes** ☐ **No** **OTHER:** Other health problems or use of medications, which might interfere with driving ability or safety? 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_____

# 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**

# CERTIFICATE OF VISUAL EXAMINATION

TOP PORTION MUST BE COMPLETED BY APPLICANT

UTAH DRIVER LICENSE DIVISION

PO 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 X:** _____ **Date** _____

***** Form will not be processed without signature*****

***(Visual Acuity/Field Report and restrictions to be filled out by Health Care Professional)***

| **Visual Acuity** | **Are lenses required while driving?** ☐ **No** ☐ **Yes** | | **Visual Field 120°** **60° to both right and left** **Private and Commercial** CDL COLOR BLIND ☐ YES ☐ NO |
|---|---|---|---|
| | **Without Correction** | **With Correction** | |
| **RIGHT EYE** | **20/** | **20/** | ☐ **YES** ☐ **NO*** |
| **LEFT EYE** | **20/** | **20/** | ☐ **YES** ☐ **NO*** |
| **BOTH EYES** | **20/** | **20/** | ☐ **YES** ☐ **NO*** |

**Safety Assessment level will be determined by the Driver License Division based on the visual acuity and visual fields provided by the Health Care Professionals, in conjunction with the "Functional Ability in Driving: Guidelines and Standards for Health Care Professionals.**

**Recommended Restrictions:**

☐ **ADD** **OR** ☐ **REMOVE**

☐ Speed-posted 40 mph or less ☐ Area

☐ Daylight only

***If visual fields are less than 120° please answer the following questions:**

☐ YES ☐ NO If visual fields are less than 120°, are they 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?

**Please answer the following questions:**

☐ YES ☐ NO With regards to driving safety, does this person have any medical conditions of significance? If so, please list condition: _____

Indicate the cause/diagnosis of the visual impairment: _____

How stable is the visual condition? _____

**Recommended interval for examination:** ☐ **Standard for Profile Level** ☐ **Other: Specify Interval** _____

**If restrictions are necessary or Medical Advisory Board review is required, additional testing/information may be requested.**

☐ I recommend this driver complete a driving skills test in an appropriate vehicle.

**Date of Examination** **Printed Name of Health Care Professional** **Signature and Degree** **State License Number**

(Must be submitted to Driver License within 6 months of exam date)

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

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

DLD 49 Rev. 12-2015

This form is ONLY required on applications for vision waivers.

# APPENDIX III

**Required for Insulin-Dependent K Restricted Drivers (Intrastate Only)**

This form is required and must be accompanied with your Functional Ability Evaluation Medical Report form if you are taking insulin to manage your diabetes. Please take this with you to your Health Care Professional **performing your diabetes examination** and have them complete and return it to:

Driver License Division
Attn: CDL Section
P O Box 144501
Salt Lake City, UT 84114-4501

**Or Fax to: 801-965-4084**

Exam completed by:_____ _____(____)_____
Signature of Health Care Professional — Medical Office Phone Number

Date of Examination:_____ Driver DOB:_____

Driver Name: _____ UT Driver License #_____
Last Name First Name Middle

**List of all insulin medications**:_____

The following conditions of **APPENDIX III**, *State of Utah Functional Ability in Driving: Guidelines and Standards for Health Care Professionals* have been met: (Please Check the appropriate column)

| Yes | No | Procedure to Complete |
|---|---|---|
| | | Patient underwent a complete medical evaluation by a health care professional who assessed the results of the following procedures prior to determine whether the person is qualified to operate a commercial motor vehicle. |
| | | 1) At least two results of glycosylated hemoglobins during the last 6 months:<br>→ A lipid profile, urinalysis and CBC<br>→ Blood Pressure, readings at rest, sitting and standing.<br>→ Elevated blood pressure, medication for hypertension or other evidence of any cardiovascular abnormality will require a maximum exercise stress EKG. |
| | | 2) Ophthalmologic Confirmation of absence of visually significant retinal disease. |
| | | 3) Examination and test to detect peripheral neuropathy and/or circulatory deficiencies of the extremities. |
| | | 4) A detailed evaluation of insulin dosages and types, diet utilized for control and any significant lifestyle factors, such as smoking, alcohol use and other medications or drugs taken. |
| | | 5) The health care professional certifies that the driver has been educated in diabetes and its control and thoroughly informed of and has demonstrated the understanding of the procedures which must be followed to monitor and manage their diabetes and what actions should be allowed. |
| | | 6) The health care professional ascertains that the driver has the ability, willingness, and equipment to properly monitor and manage their diabetes. A blood glucose monitor with electric "memory" is required. |
| | | Additional Comments: (Please attach a separate sheet if more space is needed.) |

Rev 10-06-14

This form is ONLY required on applications with Diabetes or metabolic conditions

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

# Medical Examiner's Certificate

(for Commercial Driver Medical 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
- ☐ Wearing hearing aid
- ☐ Accompanied by a _____ waiver/exemption
- ☐ Accompanied by a Skill Performance Evaluation (SPE) Certificate
- ☐ Driving within an exempt intracity zone (49 CFR 391.62) *(Federal)*
- ☐ 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's Signature**

**Medical Examiner's Telephone Number**

***Date Certificate Signed**

**Medical Examiner's Name** ***(please print or type)***

◯ MD ◯ Physician Assistant ◯ Advanced Practice Nurse
◯ DO ◯ Chiropractor ◯ Other Practitioner *(specify)* _____

**Medical Examiner's State License, Certificate, or Registration Number**

**Issuing State**

**National Registry Number**

**Driver's Signature**

**Driver's License Number**

**Issuing State/Province**

**Driver's Address**

***CLP/CDL Applicant/Holder**

Street Address: _____ City: _____ State/Province: _____ Zip Code: _____ ◯ Yes ◯ No