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