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? ☐ No ☐ 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/	☐ Yes ☐ No
Left Eye	20/	20/	☐ Yes ☐ No
Both Eyes	20/	20/	☐ Yes ☐ No
If this driver is a CDL driver, Are they color blind? ☐ Yes ☐ 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

Vision 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

Vision health care professional recommended restrictions

- ☐ Speed- posted 40mph or less ☐ Daylight only
- ☐ Area (requires driving review)

☐ Vision health care professional recommended driver review: Would require driver to complete a physical assessment, written test and driving skills test.

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