INSTRUCTIONS FOR APPLICANT:

- **Original Application** - Please have your Health Care Provider complete ALL categories of the Functional Ability Evaluation Medical Report form (FAE).

- **Renewal Application** - Please have your Health Care Provider complete the Functional Ability Evaluation Medical Report form (FAE) in the appropriate category.

- **Visual Condition** - Please have your Vision Care Provider complete the accompanying Certificate of Visual Examination.

Please DON’T FORGET TO…

- Complete the Medical questionnaire. This MUST be complete in order to process your application.

- Submit a current MEC/DOT card.

- 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

- 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 for your application processing fee. *This is a non-refundable processing fee.

- Lost enclosed Envelope? Mail to: Driver License Division, Attn: CDL Medical Program, 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 K Program representative at (801) 965-3819

If you are approved for the K Waiver Program, your K Waiver card will be mailed to the address on your driver License record. Please insure the correct mailing address is on file.
APPLICATION FOR INTRASTATE ONLY (K RESTRICTION)
MEDICAL WAIVER PROGRAM

Because I do not fully meet the minimum Federal Health requirements for an unrestricted Commercial Driver License (CDL) or a Federal DOT/ MEC Medical Card, it is my desire to apply for or renew my Utah Intrastate Only commercial driving privilege.

I understand that this process requires me to submit medical information, and in some cases will require additional information from me or my medical provider. I also understand that no processing will begin until the entire packet has been completed and turned in along with any additional requested paperwork. This can take a minimum of 4-6 weeks to process, and sometimes longer with specialized cases, or cases needing Medical Advisory Board approval.

Note: Additional Testing May be required

Applicant Signature: ________________________ Date: _____________

Full Name: ________________________________ Driver License #: ___________________

Residential Address: ___________________________________________________________

Mailing Address: ______________________________________________________________

Home Phone: ___________ Cell Phone: ___________ Work Phone: ___________

DOB: ___/___/___ SSN: ________________ Years of Commercial Driving Experience: __

Current License: Circle One
A      B      C      D

License Class Applying for: Circle One
A      B      C      D

Type of Commercial vehicle(s) expected to operate: __________________________________

Disqualifying Medical/Visual Condition: __________________________________________

List of Medications: ____________________________________________________________
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:

**Diabetes:**
- [ ] YES  [ ] NO  Do you take insulin?

**Cardiovascular:**
- [ ] YES  [ ] NO  Do you have an uncontrolled heart condition?
- [ ] YES  [ ] NO  Do you have an implantable cardioverter defibrillator (ICD)?
- [ ] YES  [ ] NO  Have you lost consciousness or fainted in the last five years?

**Pulmonary:**
- [ ] YES  [ ] NO  Do you have a pulmonary (lung) condition?
- [ ] YES  [ ] NO  Is an inhaler the only medication prescribed for this condition?
- [ ] YES  [ ] NO  Do you use supplemental oxygen?

**Neurologic:**
- [ ] YES  [ ] NO  Do you have, or have you had a neurological condition such as: Dementia, Strokes, Alzheimer’s, traumatic brain injury, Multiple Sclerosis, or Parkinson’s?

**Epilepsy:**
- [ ] YES  [ ] NO  Do you have or have you had seizures in the last five years? Or,
- [ ] YES  [ ] NO  Commercial Driver: Anytime during your life?

**Learning & Memory:**
- [ ] YES  [ ] NO  Do you have learning and memory difficulties which may interfere with driving safety?

**Mental Health Conditions:**
- [ ] YES  [ ] NO  Do you have a mental health condition such as schizophrenia, severe anxiety, or severe depression?

**Alcohol & Other Drugs:**
- [ ] YES  [ ] NO  Do you use alcohol excessively, misuse prescription drugs, or use illegal drugs?
- [ ] YES  [ ] NO  Have you been treated for alcohol or chemical dependency, or has treatment been recommended by a medical professional?

**Vision:**
- [ ] YES  [ ] NO  Are you required to wear glasses or contact lenses for driving?
- [ ] YES  [ ] NO  Is your visual acuity 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?

**Musculoskeletal:**
- [ ] YES  [ ] NO  Do you have loss or paralysis of all or part of a limb, or severe arthritis?
- [ ] YES  [ ] NO  New or Changed in the past 5 years?
- [ ] YES  [ ] NO  Present longer than 5 years

**Alertness or Sleep Disorders:**
- [ ] YES  [ ] NO  Do you have a condition that produces abnormal sleepiness (sleep apnea, narcolepsy, etc)?

**Other:**
- [ ] YES  [ ] NO  Are there any other health problems or use of medications which might interfere with driving ability or safety or control of a vehicle?
  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____

REV 06/2020
CMV DRIVER 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 (specify type): ____________________________
- 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 INFORMATION

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)

Issuing State

National Registry Number

Medical Examiner’s State License, Certificate, or Registration Number

CMV DRIVER INFORMATION

Driver’s Signature

Driver’s License Number

Issuing State/Province

Driver’s Address

Street Address: __________________________ City: __________________________ State/Province: __________ Zip Code: __________

CLP/CDL Applicant/Holder

Yes No

This document contains sensitive information and is for official use only. Improper handling of this information could negatively affect individuals. Handle and secure this information appropriately to prevent inadvertent disclosure by keeping the documents under the control of authorized persons. Properly dispose of this document when no longer required to be maintained by regulatory requirements.
COMMERCIAL DRIVER LICENSE MEDICAL SELF CERTIFICATION

49 CFR Part 383.71 and U.C.A. 53-3-410.1 require all CDL holders that operate or expect to operate a commercial motor vehicle (CMV) must meet the certification requirements outlined below. Please read the following list of options to determine which medical certification applies to the type of driving you are engaged in.

For the medical certification process to be complete, this form must be submitted to the Division:

- upon the initial issuance of any CDL or CDIP; or
- upon the upgrade of any CDL or CDIP; or
- upon the renewal of a CDL or CDIP; or
- upon the transfer of a CDL from another jurisdiction to Utah; or
- if the status indicated below changes.

Send form to: Fax # (801) 957-8633, Email dlmedcert@utah.gov, or Mail to: CDL Med Cert, PO BOX 144501 -SLC, UT 84114-4501

SELF-CERTIFICATION (Check only one box for the category that applies to you)

☐ Non-Excepted Interstate (FEDERAL) – I meet the qualification requirements under 49 CFR 391 of the Federal Motor Carrier Safety Regulations.

  - Driver drives interstate or intrastate commerce and holds a Commercial Driver License (This includes drivers that are not currently operating a Commercial Motor Vehicle);
  - Must have a valid DOT card
  - Driver must be at least 21 years old

☐ Excepted Interstate (FEDERAL) – I am exempt from the qualification requirements under 49 CFR Part 391 of Federal Motor Carrier Safety Regulations

  - Driver currently drives interstate only under excepted transportation or operations listed in 49 CFR Part 390.3 (f)
    - School bus designed to carry more than 10 passengers including the driver;
    - Transportation performed by Federal, State or an agency of State government;
    - Occasional transportation of personal property not for compensation and not in the interest of commercial enterprise;
    - Transporting human remains, or sick or injured persons;
    - Operating fire trucks and rescue vehicles while involved in emergency and related operations;
    - Operating a vehicle designed to carry 9-15 passengers including the driver not for direct compensation;
    - A driver transporting propane for winter heating fuel or a driver responding to a pipeline emergency;
    - Transporting farm operation related machinery, supplies or custom-harvested crops; or
    - Beekeeper in the seasonal transportation of bees.
  - Driver must be at least 21 years old.

☐ Non-Excepted Intrastate (STATE RESTRICTED) – I meet the qualification requirements of U.C.A. 53-3-303.5.

  - Driver has a federally disqualifying medical condition;
  - Must be accompanied by a Utah Intrastate Waiver card;
  - The driver does not meet the guidelines to obtain a valid DOT Medical Card under 49 CFR part 391;
    - Must obtain a state DOT certificate marked for accompanied by a waiver/exemption;
    - Must complete any medical reports required by the Driver License Division;
  - Must obtain a K restriction on the license and may only drive intrastate commerce.

☐ Excepted Intrastate (STATE RESTRICTED) – I meet the requirements of 49 CFR 391 with the exception that the driver is under 21 years of age.

  - Driver is under 21 years old;
  - Has a valid DOT Medical card;
  - Must have a K restriction added to the license;
  - Not eligible to drive interstate because they are under age 21.

CERTIFICATION

I understand that it is a Class B Misdemeanor to knowingly and willfully provide false information on Medical Self Certification and may result in the disqualification of my driver license pursuant to Utah Code Ann. § 76-8-504. I hereby declare under criminal penalty of the State of Utah that the information contained in this application is true and correct.

Name _______________________________ Date of Birth ___________________ DL# __________________________

Signature ____________________________ Certify Date ______________________

CDL 42 Rev 3-22
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

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/

<table>
<thead>
<tr>
<th>Visual Acuity</th>
<th>Are corrective lenses required while driving?</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] No</td>
<td>[ ] Yes  [ ] No</td>
</tr>
<tr>
<td></td>
<td>[ ] Yes</td>
<td></td>
</tr>
<tr>
<td>Right Eye</td>
<td>20/20/20/20/</td>
<td>[ ] Yes  [ ] No</td>
</tr>
<tr>
<td>Left Eye</td>
<td>20/20/20/20/</td>
<td>[ ] Yes  [ ] No</td>
</tr>
<tr>
<td>Both Eyes</td>
<td>20/20/20/20/</td>
<td>[ ] Yes  [ ] No</td>
</tr>
</tbody>
</table>

*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

<table>
<thead>
<tr>
<th>Vision health care professional recommend review time frame</th>
<th>Vision health care professional recommended restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] standard review time</td>
<td>[ ] Speed- posted 40mph or less</td>
</tr>
<tr>
<td>[ ] six month review time</td>
<td>[ ] Daylight only</td>
</tr>
<tr>
<td>[ ] one year review time</td>
<td>[ ] Area (requires driving review)</td>
</tr>
<tr>
<td>[ ] upon renewal of license</td>
<td>[ ] Vision health care professional recommended driver review: Would require driver to complete a physical assessment, written test and driving skills test.</td>
</tr>
<tr>
<td>[ ] no further review</td>
<td></td>
</tr>
<tr>
<td>[ ] Other</td>
<td></td>
</tr>
<tr>
<td>[ ] there are special considerations I would like to discuss</td>
<td></td>
</tr>
</tbody>
</table>

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 driver’s 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)
# Functional Ability Evaluation Medical Report

Utah Driver License Division  
P.O. Box 144501  
SLC, UT 84114-4501  
Phone: 801-957-8690  
Fax: 801-957-8698  
Email: dlmedical@utah.gov

---

<table>
<thead>
<tr>
<th>A Diabetes and metabolic conditions</th>
<th>B Cardiovascular</th>
<th>C Pulmonary</th>
<th>D Neurologic</th>
<th>E Seizures &amp; Episodic Conditions</th>
<th>F Learning &amp; Memory</th>
<th>G Mental Health</th>
<th>H Alcohol &amp; Other drugs</th>
<th>J Musculo-Skeletal Or chronic Debility</th>
<th>K Alertness Or Sleep disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Insulin dependent</td>
<td>□ Hypertension Only</td>
<td>□ Oxygen w/driving</td>
<td>□ Inhaler only</td>
<td>Date of last Seizure</td>
<td>Date of last Seizure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
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<td>10</td>
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<tr>
<td>1 No driving</td>
<td>2 No driving</td>
<td>3 No driving</td>
<td>4 No driving</td>
<td>5 No driving</td>
<td>6 No driving</td>
<td>7 No driving</td>
<td>8 No driving</td>
<td>9 No driving</td>
<td>10 No driving</td>
</tr>
</tbody>
</table>

**Health care professional recommended 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

**Health Care professional recommended restrictions**

- □ Speed- posted 40mph or less  
- □ Area (requires driving review)  
- □ Supplemental Oxygen while driving  
- □ Daylight driving only  
- □ Health care professional recommended driver review:
  
  Would require driver to complete a physical assessment, written test and driving skills test.

---

Is there a disorder or condition that is not marked that is relevant to safe driving for this driver? If so, what categories do you recommend?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

---

*required responses for submission in applicable scenarios. (Submission will not be accepted if older than 6 months or if required medical information is missing)

---

1. **Exam Date**  
   - *Printed Name of Health Care Professional*  
   - *Signature & degree*  
   - *State license number*

   **Form signed Date**  
   - *Street Address*  
   - City  
   - State  
   - Zip Code  
   - *Telephone*

2. **Exam Date**  
   - *Printed Name of Health Care Professional*  
   - *Signature & degree*  
   - *State license number*

   **Form signed Date**  
   - *Street Address*  
   - City  
   - State  
   - Zip Code  
   - Telephone

---

DLD 134 REV. 04-22
<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAFETY ASSESSMENT LEVELS</strong></td>
<td><strong>Diabetes &amp; Metabolic Conditions</strong></td>
<td><strong>Cardio-vascular</strong></td>
<td><strong>Pulmonary</strong></td>
<td><strong>Neurologic</strong></td>
<td><strong>Seizures &amp; Episodic Conditions</strong></td>
<td><strong>Learning Memory Condition</strong></td>
<td><strong>Mental Health</strong></td>
<td><strong>Alcohol &amp; Other Drugs</strong></td>
<td><strong>Musculo-skeletal or Chronic Deblity</strong></td>
<td><strong>Alertness or Sleep Disorders</strong></td>
</tr>
<tr>
<td>1</td>
<td>No history. No further review</td>
<td>No past history or fully recovered. No further review</td>
<td>No history or fully recovered. No further review</td>
<td>No history or fully recovered. No further review</td>
<td>No history or fully recovered within 2 years. No further review</td>
<td>No history or fully recovered within 2 years. No further review</td>
<td>No history or fully recovered within 2 years. No further review</td>
<td>No history or fully recovered within 2 years. No further review</td>
<td>No history or fully recovered within 2 years. No further review</td>
<td>No history or fully recovered within 2 years. ESS -6. No further review</td>
</tr>
<tr>
<td>2</td>
<td>Stable with diet and/or non-insulin stimulating meds. No further review**</td>
<td>All AHA Class I: isolated arrhythmia, no limits, no symptoms on ordinary activity. No further review</td>
<td>Minimal symptoms. Sporadic use of meds. No steroids. 1 yr. review</td>
<td>Minimal impairment, able to control equipment in conventional manner. 5 yr. review</td>
<td>Single seizure but none in past 5 years, and off meds for at least 4 years. 2 yr. review</td>
<td>Minimal difficulty with good social and personal adjustment. No interval for review</td>
<td>Stable at least 1 year with or w/o meds; no psychiatric hospitalization for at least 1 year. 1 yr. review</td>
<td>No adverse consequences within past year. 1 yr. review</td>
<td>Mild residual loss of function. 5 yr. review. 2 yr. review for CDL</td>
<td>Problems with good self-management ESS 7-9. 2 yr. review</td>
</tr>
<tr>
<td>3</td>
<td>Stable on meds that stimulate insulin production. No further review**</td>
<td>AHA Class I; rhythm normal or stable with pacemaker for 6 months; 1 yr. min symptoms w/seniorous activity. 1 yr. review</td>
<td>Symptoms on activity, intermitent seconis FVC &amp; FEV &gt; 65% to 70% of predicted normal. 1 yr. review</td>
<td>Moderate impairment of dexterity. 1 yr. review</td>
<td>Seizure free 1 year more, or on medication, followed by additional 1 yr off meds remaining seizure free. 1 yr. review</td>
<td>Slight impairment w/good socialization &amp; emotional control. 5 yr. review</td>
<td>Stabile at least 6 months with or w/o meds; no psychiatric hospitalization for at least 6 months. 6 m. review</td>
<td>No adverse consequences within past 6 months. 6 m. review</td>
<td>Moderate residual loss of function or without compensatory device. 2 yr. review. Skills test on initial assessment</td>
<td>Mild/moderate problems, good professional management ESS 10-12. 1 yr. review</td>
</tr>
<tr>
<td>4</td>
<td>Stable on insulin for 1 year. 1 yr. review</td>
<td>AHA Class II; rhythm stable with O2 or noninspiratory or spontaneous with no complaints, no cough syncope 6 months. 1 yr. review</td>
<td>Stable with O2 or noninspiratory or spontaneous with no complaints, no cough syncope 6 months. 1 yr. review</td>
<td>Moderate impairment of dexterity or decreased stamina. 1 yr. review</td>
<td>Seizure free 1 year more on AED medication w/o side effects. 1 yr. review</td>
<td>Moderate impairment w/good socialization &amp; emotional control. 3 yr. review. 2 yr. review for CDL</td>
<td>Skills test on initial assessment</td>
<td>Stabile at least 3 months with or w/o meds; no psychiatric hospitalization for 3 months. 3 m. review</td>
<td>No adverse consequences within past 3 months. 3 m. review</td>
<td>Moderate problems related to time of day ESS 13-15. 6 m. review. Daylight restriction</td>
</tr>
<tr>
<td>5</td>
<td>Stable on insulin for 6 months but &lt; than 1 yr. review 1 yr. review</td>
<td>AHA Class III; anticipated aggravation by unlimited driving. 1 yr. review</td>
<td>PO2 over 50, symptoms w/ordinary activity, no cough syncope 3 months. 6 m. review</td>
<td>Moderate neurologic impairment expected to be temporary. 6 m. review. Skills test S.A.D.*</td>
<td>Seizure free 6 months to 1 yr. on AED medication w/o side effects. 6 m. review</td>
<td>NOT USED No definition</td>
<td>Stable at least 1 month with meds; no psychiatric hospitalization for 1 month. 6 m. review</td>
<td>No adverse consequences within past 1 month. 3 m. review</td>
<td>Limited joint motion, deformity of limb or spine; amputation. 1 yr. review. Skills test on initial assessment</td>
<td>Moderate problems related to time &amp; circumstances ESS 13-15. 6 m. review. S.A.D.*</td>
</tr>
<tr>
<td>6</td>
<td>Stable on insulin for 3 months but &lt; than 6 months 6 month review</td>
<td>AHA Class III; unstable rhythm 6 m. review. S.A.D.*</td>
<td>Severe dyspnea; cough syncope within 3 months. 6 m. review. S.A.D.*</td>
<td>NOT USED No definition</td>
<td>Seizure free 3 months to 6 months on AED. Level not applicable for CDL. 6 m. review</td>
<td>Moderate impairment, or variable competence or control. 1 yr. review. Skills test on initial assessment. S.A.D.*</td>
<td>Minimal dyskinesia, or meds which minimally interfere with coordination. 6 m. review</td>
<td>Intermittent impairment of function, not while driving or working. 3 m. review. S.A.D.*</td>
<td>NOT USED No definition</td>
<td>NOT USED No definition</td>
</tr>
<tr>
<td>7</td>
<td>Special Circumstances or under evaluation</td>
<td>NOT USED No definition</td>
<td>Special Circumstances or under evaluation</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>8</td>
<td>NO DRIVING: Driving skills test is not allowed for a safety assessment level 8</td>
<td>Severe, unstable, uncontrolled physical, mental or emotional impairments or conditions; with or without loss of consciousness or syncope; or severe current condition requiring hospitalization; chronic use of alcohol or drugs creating impairment or unsafe conditions; or incapacitating problems or issues that affect driving alertness, safety, coordination or ability.</td>
<td></td>
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</tbody>
</table>

* Level requires a speed, area, or daylight restriction
** Unless review is requested by Healthcare provider

Interval for review may be made longer at physician discretion