



**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?		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.
	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
	Without Correction	With Correction	
Right Eye	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No
Left Eye	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No
Both Eyes	20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No
If this driver is a CDL driver, Are they color blind? <input type="checkbox"/> Yes <input type="checkbox"/> 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

<p><b>Vision health care professional recommend review time frame</b></p> <p><input type="checkbox"/> standard review time</p> <p><input type="checkbox"/> six month review time</p> <p><input type="checkbox"/> one year review time</p> <p><input type="checkbox"/> upon renewal of license</p> <p><input type="checkbox"/> no further review</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> there are special considerations I would like to discuss</p>	<p><b>Vision health care professional recommended restrictions</b></p> <p><input type="checkbox"/> Speed- posted 40mph or less    <input type="checkbox"/> Daylight only</p> <p><input type="checkbox"/> Area (requires driving review)</p> <p><input type="checkbox"/> vision health care professional recommended driver review: Would require driver to complete a physical assessment, written test and driving skills test.</p>
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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