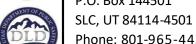


Certificate of Visual Examination

Utah Driver License Division P.O. Box 144501 SI.C. UT 84114-4501



Phone: 801-965-4437 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 administrative action. Medical Insafety and driving. For more information be found on our website at h	formation submitted on this formation on how to submit this	rm should be restricted to info form, visit dld.utah.gov. A full	ormation that is neede	ed in relation to public	
Visual Acuity	Are corrective lenses ☐ No	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	
	Without Correction	With Correction	the same whether the driver is a CDL or private operator.		
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 t	they color blind?	□ No	-		
*If visual fields are less than 120 Are the visual fields at least 90°, *If visual fields are less than 90°,	with 45° to both the right and	left of fixation?	□ No ation? □ Yes	□No	
Vision health care professional	recommend review time frame	Vision health care p	Vision health care professional recommended restrictions		
□ standard review time □ six month review time □ one year review time			☐ Speed- posted 40mph or less ☐ Daylight only ☐ Area (requires driving review)		
□ upon renewal of license □ no further review □ Other □ there are special considerations I would like to discuss		Would require driver to	☐ 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 i	s relevant to driving and public	safety for this driver? If so, wh	at medical condition		
How stable is this drivers visual co	<u></u>				
*required responses for sub	mission in applicable scenarios. (Submi	ission will not be accepted if older than	n 6 months or if required m	edical information is missing)	
*Exam Date	Printed Name of Health Care Professional *Signature & degree State license number				
*Form signed Date	*Street Address		State Zip Code	*Telephone	