



Invisible Condition Request Form

Utah Driver License Division

P.O. Box 144501

SLC, UT 84114-4501

Phone: 801-963-7325 Fax: 801-957-8698 Email:dlmedical@utah.gov

First Name

Last Name

Date of Birth

Driver License/Identification Card Number

I request the Driver License Division place an invisible condition identification symbol on my record. I further request to have the information shared on the Utah Criminal Justice system for law enforcement. In accordance with UCA §53-3-207;

- I voluntarily release my medical information and waive any and all claims against the Department of Public Safety, Driver License Division or any person who may have access to my medical information as contained in my driving record and/or any other person who may view or receive notice of my medical information by viewing my driver license or identification card.
- I am consenting to the release of the medical information listed on this form, and waive any claims of privacy regarding this medical information under state or federal law.
- I understand that the inclusion of the invisible condition symbol on my Driver License or Identification card does not confer any legal rights or privileges to me, including but not limited to parking privileges for individuals with disabilities.

Applicant's Signature

Date

The individual listed above has the following invisible condition(s):

- | | | |
|--|--|---|
| <input type="checkbox"/> Communication impediment | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Traumatic brain injury |
| <input type="checkbox"/> Post traumatic stress disorder | <input type="checkbox"/> Drug allergy | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Blindness or visual impairment | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Developmental disability |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Down syndrome |
| <input type="checkbox"/> Alzheimer's disease or dementia | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Other: _____ |

Dr. Comments: _____

By signing below I certify that I am a healthcare professional as defined in UCA §53-3-207 and the individual above has the listed conditions(s).

Printed name of HCP and degree

Signature

State license number

Street address

City

State

Zip

Telephone