# CERTIFICATE OF VISUAL EXAMINATION

TOP PORTION MUST BE COMPLETED BY APPLICANT

UTAH DRIVER LICENSE DIVISION

PO BOX 144501
SLC UT 84114-4501
PHONE NUMBER (801) 965-4437

www.driverlicense.utah.gov

**FAX NUMBER**
**(801) 957-8698**

*For Office Use Only:*
☐ Private Vehicle Driver
☐ Commercial Vehicle Driver

**Last Name** **First Name** **Middle or Maiden Name** **Date of Birth** **Driver License or Driving Privilege Card Number**

**Street Address** **City** **State** **Zip Code** **Social Security Number / ITIN**

☐ The address above is different from the address showing on my Driver License or Driving Privilege Card.
If you have a commercial license you will need to appear at a commercial driver license office to obtain a new license with your correct address.

**By signing this form**, I authorize my healthcare professional(s) to disclose specific health information regarding my physical, mental and emotional condition relevant to my ability to safely operate a motor vehicle, to the Utah Driver License Division, P.O. Box 30570, Salt Lake City, Utah 84130-0570. This authorization is valid for five years or the period of time needed to fulfill its purpose, whichever comes first. I also understand that I may revoke this authorization at any time, by sending written notification to the Utah Driver License Division at the above address.

I understand that if I fail to sign this authorization my driving privilege may be affected. I understand that this information may no longer be protected in accordance with HIPPA but will be classified as a private record in accordance with GRAMA (UCA 63-2-202). Individuals who are entitled to have a "private" record disclosed to them are limited to the subject of the record, a parent or legal guardian of an unemancipated minor or legally incapacitated individual, an individual with power of attorney or a notarized release signed by the subject of the record, or an individual with a court or legislative subpoena.

**Applicant's Signature X:** **Date**

****** Form will not be processed without signature.******

**(*Visual Acuity Report and restrictions to be filled out by Health Care Professional.*)**

| Visual Acuity | Are lenses required while driving? ☐ No | ☐ Yes | Visual Field 120° 60° to both right and left Private and Commercial CDL COLOR BLIND ☐ YES ☐ NO |
|---|---|---|---|
| | Without Correction | With Correction | |
| RIGHT EYE | 20/ | 20/ | ☐ YES ☐ NO |
| LEFT EYE | 20/ | 20/ | ☐ YES ☐ NO |
| BOTH EYES | 20/ | 20/ | ☐ YES ☐ NO |

**Circle Profile Level: 1 2 3 4 5 6 7 8 9 10** Shaded areas require Medical Advisory Board review

**Restrictions:** ☐ Speed ☐ Area ☐ Daylight Only ☐ Accompanied by Licensed Driver

☐YES ☐NO If visual fields are less than 120°, are they 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 Does the patient have diabetes mellitus, cardiac disease, hypertension, or any other systemic disease that may affect driving? ______________________________

Indicate the etiology of the visual impairment:______________________________
How stable is the visual condition? ______________________________
Recommended interval for examination: ☐ Standard for Profile Level ☐ Other: Specify Interval______________
☐ I recommend this driver complete a driving skills test in an appropriate vehicle.

**Date of Examination** *(Current within 6 months)* **Printed Name of Health Care Professional** **Signature and Degree** **State License Number**

**Street Address** **City** **State** **Zip Code** **Telephone** **Fax Number**

*For Office Use Only:* **DLD Screening**

**Date of Examination** **Signature** **Employee Number** **Field Station**