CERTIFICATE OF VISUAL EXAMINATION

TOP PORTION MUST BE COMPLETED BY APPLICANT

FAX NUMBER
(801) 957-8698

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

UTAH DRIVER LICENSE DIVISION

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

www.driverlicense.utah.gov

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 144501, Salt Lake City, Utah 84114-4501. 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 63G-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
	Claron D. Alldredge, M.D.		5216808-1205

Street Address	City	State	Zip Code	Telephone	Fax Number
440 D Street, Suite 210,	Salt Lake City,	Utah	84103	(801) 408-3705	(801) 408-3706

For Office Use Only: **DLD Screening**

Date of Examination	Signature	Employee Number	Field Station