

# FUNCTIONAL ABILITY EVALUATION MEDICAL REPORT

UTAH DRIVER LICENSE DIVISION  
 P O BOX 144501  
 SLC UT 84114-4501  
 Phone Number: (801) 957-8690  
 Fax Number: (801) 957-8698

**TOP PORTION MUST BE COMPLETED AND SIGNED BY APPLICANT**

Last Name First Name Middle or Maiden Name Date of Birth Driver License or DPC #

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.

I understand that if I fail to sign this authorization my driving privilege may be affected. I understand that this information 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:** \_\_\_\_\_



**Date:** \_\_\_\_\_

Form will not be processed without signature

**BOTTOM PORTION TO BE COMPLETED AND SIGNED BY HEALTH CARE PROFESSIONAL**

The following safety assessment level is for use in determining driving privileges. It is consistent with the current edition of **Functional Ability in Driving: Guidelines and Standards for Health Care Professionals**. Please indicate level below with a check mark and your initials.

Safety Assessment Level	A Diabetes & Metabolic Condition <b>On Insulin</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	B Cardio-Vascular & High Blood Pressure	C Pulmonary <input type="checkbox"/> Inhaler Only <input type="checkbox"/> Oxygen w/Driving	D Neurologic	E Seizures or Episodic Conditions <input type="checkbox"/> Date of last seizure _____	F Learning Memory	G Psychiatric or Emotional Condition	H Alcohol & Other Drugs	J Musculo-skeletal/Chronic Debility	K Alertness or Sleep Disorders	L <input type="checkbox"/> Hearing <input type="checkbox"/> Balance
	1										
2											
3											
4											
5						N/A					
6				N/A	N/A				N/A	N/A	N/A
7					N/A						
8											

Please indicate if any of the following apply to this medical review:

- Non-standard review time frame \_\_\_\_\_
- Safety Assessment categories not marked are relevant and should be completed by another health care professional. Please list categories which are of concern: \_\_\_\_\_

**Recommended Restrictions:**

ADD OR  REMOVE

Speed-posted 40 mph or less     Area

Oxygen while driving                       Daylight only

I recommend this driver complete a driving skills test in an appropriate vehicle. (Drive test is not available for level 8)

Date form is completed Printed Name of Health Care Professional and Degree Signature & initials State License Number  
 (Must be submitted to Driver License within 6 months)

Street Address City State Zip Code Telephone Fax Number

Doctor's Comments \_\_\_\_\_

- There are special considerations I would like to discuss with a representative of the Division.

Date form is completed Printed Name of Health Care Professional and Degree Signature & initials State License Number  
 (Must be submitted to Driver License within 6 months)

Street Address City State Zip Code Telephone Fax Number

Doctor's Comments \_\_\_\_\_

- There are special considerations I would like to discuss with a representative of the Division.

For more information regarding the medical program or to view current medical guidelines, please visit: