



Colorado Intrastate CDL Medical Waiver Programs

Applicant Information Form

In addition to this form, there are 4 other items required for a complete application.

Application is for which type of waiver (CHOOSE ONLY one):

DIABETES (*insulin-dependent*) ☐

VISION ☐

LIMB/SPE ☐

1. Driver Information

Name (First, Middle Initial, Last): _____

Street Address: _____

City, State and ZIP code: _____

Mailing Address, if different: _____

City, State and ZIP code: _____

Phone: _____

Cell: _____

Email Address: _____

Date of Birth: _____

Sex: Male ☐

Female ☐

2. Drivers' License –License # and Commercial Class _____

- a. If you don't have a commercial license/permit, are you applying for one? YES ☐ NO ☐

Attach a **LEGIBLE** copy of both sides of your current Colorado drivers' license.

3. Statements of Driver Qualification and Authorization (to be signed by the applicant)

- a) I hereby certify that I am otherwise qualified under 49 CFR 391.41(b)(1-13) to operate a CDL-required vehicle in INTRASTATE commerce. *I understand and agree that any false statements made to obtain this intrastate waiver may cause the cancellation of my waiver. I further agree to abide by the restrictions, conditions, and requirements of the Colorado CDL Medical Waiver Program.*

Applicant Signature: _____

- b) I authorize the physician completing this waiver application on my behalf to discuss and release any and all medical records pertaining to its content with or to the Colorado State Patrol, Medical Waiver Program Manager or designee.

Applicant Signature: _____

Date _____

Print Name: _____

APPLICATION PACKET REQUIREMENTS

The following information is required in order for your application to be processed:

- Applicant Information Form (this form);
- Copy of the Medical Examination Report (also known as the long form) completed by an examiner listed on the National Registry of Medical Examiners;
- Copy the Medical Examiners Certificate (DOT card) completed by the same examiner as above;
- Medical waiver application form(s) for the condition to be waived, completed by the applicant's physician; and,
- Copy of your current Driver's License-front and back

MAIL TO: Colorado State Patrol-Motor Carrier Unit, ATTN: Medical Waivers,
15075 South Golden Road, Golden, CO 80401
OR call 303-273-1875 for a personal appointment
<https://www.colorado.gov/csp/medical-waivers>



Drivers' Name _____ Date of Birth _____

In addition to this form, there are 4 other items required for a complete application.
Applicant Information Form – Medical Examination Report – Medical Examiner's Certificate – Copy of drivers' license (front and back)

PHYSICIAN VISION EVALUATION FORM

Colorado Intrastate CDL Vision Waiver Program

Instructions for the Physician

Please type or print your answers legibly. **The waiver application must be completed and signed by an ophthalmologist or optometrist.** State license number must also be included.

This CDL driver/applicant is applying for a waiver from the Federal vision standard 391.41(b)(10). If granted, this would allow the individual to operate a commercial motor vehicle (large truck or bus) in intrastate commerce (operations in Colorado only). A large part of the application process is your evaluation to determine if this individual has any medical problem related to visual acuity that might impair safe driving.

Key points to consider during your evaluation are:

- stability of the condition
- likelihood of condition creating sudden or unexpected incapacitation while driving
- likelihood of condition interfering in normal and safe operation a commercial vehicle
- adaptation to the condition

All items must be completed.

1. Date of examination: _____
2. Identify and define the nature of the visual deficiency. _____

3. What is the applicant's best corrected visual acuity:
Right 20/ _____ Left 20/ _____ Both 20/ _____
Monocular vision? **YES** **NO**
4. Is the applicant's horizontal field of vision, including central and peripheral fields, at least 120° in the horizontal. **YES** **NO**
5. Is the visual deficiency stable? **YES** **NO**
6. Can the applicant recognize the standard traffic signal colors of red, green, and amber?
YES **NO**

Physician's Name (Print): _____

Address: _____

Phone: _____ State License Number _____

- ❖ I hereby certify that in my medical opinion, the applicant has sufficient vision to perform the driving tasks required to safely operate a commercial motor vehicle (CMV) in intrastate commerce (Colorado only).
YES **NO**

Physician's Medical Evaluation is valid for what length of time? (Not longer than 2 years) _____

Restrictions, if any (side mirrors, etc.): _____

Physician's Signature: _____ Date: _____

FOR COLORADO STATE PATROL WAIVER PROGRAM USE ONLY

APPLICATION REVIEWED BY (PRINT)

DATE

APPROVED

☐

NOT APPROVED – RETURNED TO APPLICANT FOR
INFORMATION

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