

City of Wolverhampton Council Licensing Services

Hackney Carriages and Private Hire Vehicle Driver Medical Certificate

Full Name of Applicant (Capitals) _____

Address: _____ Postcode _____

I hereby authorise my doctor(s) and specialists to release reports/medical information to the Medical Practitioner, should they require further information about condition(s) relevant to my fitness to drive to group 2 standard.

Signature of applicant _____
(To be signed in the presence of the medical practitioner signing this certificate)

You are Assessing Fitness to Drive at DVLA Group 2 Standard, a guidance for medical professionals is available online at <https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals>
This medical must be completed in person and not remotely.

The applicant has provided one from each type of the following forms of identification,
Type 1: Passport Driving Licence
Type 2: Utility Bill (gas, electric, telephone, water) Bank Statement
Birth Certificate Marriage/Civil Partnership Certificate:

Date of Birth of applicant ____ / ____ / ____ Age of applicant _____

Medical certification frequency requirement

- A new certificate must be produced every 5 years after the applicant's 45th birthday.
- Once the age of 65 is reached, a medical certificate must be produced every year.

Earlier medical certification frequency requirement

The above medical certification frequency is not sufficient: (tick box if applicable) and I recommend that the applicant is examined no later than: (insert date) _____

I certify that I have on this day examined the applicant, who signed this form in my physical presence and showed two forms of identification as indicated above and they have provided me with their full medical records obtained within the last month for which I have reviewed to ascertain their medical fitness to Group 2 Standards and I declare that they meet the below:

Medically Fit Medically unfit to drive a hackney carriage or private hire vehicle.

Name of GMC registered Medical Practitioner _____

Signature of GMC registered Medical Practitioner _____ Date ____ / ____ / ____.

GMC Reference Number

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Taxi Medical Please add address and phone number
Motor Medicals or Medical Practice Address Stamp
0161 241 9622
Motormedicals.com/taxi No disclaimers are acceptable.