MEDICAL CERTIFICATE
ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

This Medical Certificate is compiled with regard to the recommendations by the The Royal Society of Medicine Press Limited Booklet "Fitness to Drive - A Guide for Health Professionals". All standards contained within this certificate are meant as guidelines only, it is to the discretion of the Medical Practitioner to decide the fitness of the applicant. This certificate is for the confidential use of the Licensing Authority.

Any fee charged is payable direct by the applicant to the Medical Practitioner. The Council accepts no liability to pay for any Medical examinations.

This form must be completed on examination for all new applicants. In the case of renewal applications, the frequency of repeat medical certificates is dependant on the age of the applicant, as follows:

Up to Age 65	Every 5 Years
Age 65+	Every Year

Except where an additional medical certificate is required as per the recommendation of a registered medical practitioner, or in cases where specific medical conditions come to the attention of the Council or are known about.

STRICTLY CONFIDENTIAL

Medical Examination Report (Group 2)

To be completed by the Doctor and by the Patient at section 9 and 10 in the Doctor's presence (please use black ink)

Please answer **all** questions.

Please give patient's weight (kg/st) height (cms/ ft) ---

Please give details of smoking habits, if any ---

Please give number of alcohol units taken each week --

Is the urine analysis positive for Glucose? (please tick appropriate box) Yes ☐ No ☐

Details of specialist(s)/consultants, including address:

1.	2.	3.

Specialty:

Date last seen:

Medication	dosage	reason taken

Date when first licensed to drive a licensed Hackney Carriage / Private Hire Vehicle: / /

1. Vision

Please tick ✓ the appropriate box(es) YES NO

1. Is the visual acuity **at least** 6/9 in the better eye and at least 6/12 in the other?

(corrective lenses may be worn) as measured with the full size 6m snellen chart ☐ ☐

2. Do corrective lenses have to be worn to achieve this standard? ☐ ☐

If **YES,** is the:-

(a) uncorrected acuity at least 3/ 60 in the right eye? ☐ ☐

(b) uncorrected acuity at least 3/ 60 in the left eye? ☐ ☐

(3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)

(c) correction well tolerated? ☐ ☐

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart.
Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected
Right ☐ Left ☐

Corrected (if applicable)
Right ☐ Left ☐

YES NO

4. Is there a defect in his/her binocular field of vision (central and/or peripheral)? ☐ ☐

5. Is there diplopia? (controlled or uncontrolled)? ☐ ☐

6. Does the applicant have any other ophthalmic condition? ☐ ☐
If **YES** to 4, 5 or 6, please give details in **Section 7** and enclose any relevant visual field charts or hospital letters.

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2 Nervous System

YES NO

1. Has the applicant had any form of epileptic attack?

(a) If **Yes,** please give date of last attack

(b) If treated, please give date when treatment ceased

(c) Is the applicant currently on anti-epileptic medication?
If **Yes,** please complete current medication on the appropriate section on page 2 of this document

2. Is there a history of blackout or impaired consciousness within the last 5 years?
If **YES,** please give date(s) and details in **Section 7**

3. Does the applicant suffer from narcolepsy/cataplexy?
If **YES,** please give details in **Section 7**

4. Is there a history of, or evidence of any of the conditions listed at a–h below?
If **NO,** go to **Section 3.**

If **YES,** please tick the relevant box(es) and give dates and full details at **Section 7.**

(a) Stroke/ TIA *please delete as appropriate*

If **YES**, please give date has there been a **full** recovery?

(b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur

(c) Subarachnoid haemorrhage

(d) Serious head injury within the last 10 years

(e) Brain tumour, either benign or malignant, primary or secondary

(f) Other brain surgery

(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis

(h) Dementia or cognitive impairment

3. Diabetes Mellitus

YES NO

1. Does the applicant have diabetes mellitus?

If **NO,** please proceed to **Section 4**
If **YES,** please answer the following questions.

2. Is the diabetes managed by:-

(a) Insulin?
If **YES**, please give date started on insulin / /

(b) Exenatide/Byeta

(c) Oral hypoglycaemic agents and diet?
If **Yes,** please complete current medication on the appropriate section on the front of this form

(d) Diet only?

3. Does the applicant test blood glucose at least twice every day?

4. Is there evidence of:-

(a) Loss of visual field?

(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?

(c) Diminished/Absent awareness of hypoglycaemia?

5. Has there been laser treatment for retinopathy?
If **YES,** please give date(s) of treatment

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6. Is there a history of hypoglycaemia during **waking** hours in the

last 12 months requiring assistance from a third party?

If **YES** to any of 4–6 above, please give details in **Section 7**

4. Psychiatric Illness

	YES	NO
Is there a history of, or evidence of any of the conditions listed at 1–6 below?	☐	☐

If **NO,** please go to **Section 5**
If **YES** please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7.**

NB. Please enclose relevant hospital notes

NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1.

	YES	NO
1. Significant psychiatric disorder within the past 6 months	☐	☐
2. A psychotic illness within the past 3 years, including psychotic depression	☐	☐
3. Persistent alcohol misuse in the past 12 months	☐	☐
4. Alcohol dependency in the past 3 years	☐	☐
5. Persistent drug misuse in the past 12 months	☐	☐
6. Drug dependency in the past 3 years	☐	☐

5. Cardiac

Please follow the instructions in all Sections (5A–5G) giving details as required in Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 1.

5a. Coronary Artery Disease

	YES	NO
Is there a history of, or evidence of, coronary artery disease?	☐	☐

If **NO,** proceed to **Section 5B**
If YES please answer all questions below and give details at Section 7 of the form.

	YES	NO
1. Acute Coronary Syndrome including Myocardial Infarction? If **Yes,** please give date(s) / /	☐	☐
2. Coronary artery by-pass graft surgery? If **Yes,** please give date(s) / /	☐	☐
3. Coronary Angioplasty (P.C.I) If **Yes,** please give date(s) / /	☐	☐
4. Has the applicant suffered from Angina? If **Yes,** please give the date of the last attack / /	☐	☐

Please proceed to next Section 5B

5b Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	☐	☐

If **NO,** proceed to **Section 5C**

If **YES** please answer all questions below and give details at **Section 7** of the form.

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1. Has there been a **significant** disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in last 5 years ☐ ☐

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? ☐ ☐

3. Has a cardiac defibrillator device (I.C.D) been implanted? ☐ ☐

4. Has a pacemaker been implanted? ☐ ☐
If **YES:-**
(a) Please supply date / /

(b) Is the applicant free of symptoms that caused the device to be fitted? ☐ ☐

(c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐
Please proceed to next Section 5C

5c. Peripheral Arterial Disease (excluding Buerger's Disease)

1. Is there a history or evidence of ANY of the below:

If **YES** please **tick ✓ all** relevant boxes below, and give details at **Section 7** of the form.

YES NO

2. Does the patient have claudication? ☐ ☐
If **YES** how long in minutes can the patient walk at a brisk pace before being symptom limited?

Please give details

AORTIC ANEURYSM ☐ ☐
IF YES:

(a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐

(b) Has it been repaired successfully? ☐ ☐

(c) Is the transverse diameter **currently** 5.5cms? ☐ ☐

DISSECTION OF THE AORTA
IF REPAIRED SUCCESSFULLY:

(d) Please provide sight of reports to confirm if available ☐ ☐
Please proceed to next Section 5D

5d. Valvular/Congenital Heart Disease

Is there a history of, or evidence, of valvular/congenital heart disease? ☐ ☐
If **NO,** proceed to **Section 5E**
If **YES** please answer all questions below and give details at **Section 7** of the form.

1. Is there a history of congenital heart disorder? ☐ ☐

2. Is there a history of heart valve disease? ☐ ☐

3. Is there any history of embolism? (**not** pulmonary embolism) ☐ ☐

4. Does the applicant currently have significant symptoms? ☐ ☐

5. Has there been any progression since the last licence application? (if relevant) ☐ ☐
Please proceed to next section 5E

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5e Cardiac Other

Does the applicant have a history of ANY of the following conditions:

(a) a history of, or evidence of heart failure? ☐ ☐

(b) established cardiomyopathy? ☐ ☐

(c) a heart or heart/lung transplant? ☐ ☐

If YES to any part of the above, please give full details in Section 7 of the form. If NO, proceed to next section 5F.

5f Cardiac Investigations

This section must be completed for all applicants. Yes No

1. Has a resting ECG been undertaken? ☐ ☐
If **YES,** does it show:-

(a) pathological Q waves? ☐ ☐

(b) left bundle branch block? ☐ ☐

(c) right bundle branch block? ☐ ☐

2. Has an exercise ECG been undertaken (or planned)? ☐ ☐
If **YES,** please give date and give details in **Section 7** / /
Please provide if available

3. Has an echocardiogram been undertaken (or planned)? ☐ ☐
(a) If **YES,** please give date and give details in **Section 7** / /

(b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%? ☐ ☐

Please provide if available

4. Has a coronary angiogram been undertaken (or planned)? ☐ ☐
If **YES,** please give date and give details in **Section 7** / /
Please provide if available

5. Has a 24 hour ECG tape been undertaken (or planned)? ☐ ☐
If **YES,** please give date and give details in **Section 7** / /
Please provide if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? ☐ ☐
If **YES,** please give date and give details in **Section 7** / /
Please provide if available
Please proceed to Section 5G

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5g. Blood Pressure

This section must be completed for all applicants **YES** **NO**

1. Is today's best reading systolic pressure 180mm Hg or greater? ☐ ☐

2. Is today's best reading diastolic pressure 100mm Hg or greater? ☐ ☐

3. Is the applicant on anti-hypertensive treatment? ☐ ☐
If YES, to any of the above, please supply today's best reading and three previous readings with dates, if available

6. General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 7.

YES **NO**

1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle? ☐ ☐

2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? ☐ ☐

If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination

YES **NO**

3. Is the applicant profoundly deaf? ☐ ☐

If **YES**, is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/ text phone? ☐ ☐

4. Is there a history of either renal or hepatic failure? ☐ ☐

5. Does the applicant have sleep apnoea syndrome? ☐ ☐
If **YES**, please supply details
(a) Date of diagnosis / /

(b) Is it controlled successfully? ☐ ☐

(c) If **YES**, please state treatment

(d) Please state period of control

(e) Please provide neck circumference

(f) Please provide girth measurement in cms

(g) Date last seen by consultant

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	YES	NO
6. Is there any other **Medical Condition**, causing excessive daytime sleepiness? If **YES**, please supply details	☐	☐

(a) Diagnosis

(b) Date of diagnosis / /

(c) Is it controlled successfully? ☐ ☐

(d) If **YES**, please state treatment

(e) Please state period of control

(e) Date last seen by consultant

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
8. Does any medication currently taken cause the applicant side effects that could affect safe driving?	☐	☐

If **YES**, please supply details of medication:

9. Does the applicant have any other medical condition that could affect safe driving? If **YES**, please supply details:	☐	☐

7 **Please forward copies of relevant hospital notes only. Please do not send any notes not related to fitness to drive**

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Medical Practitioner Details

To be completed by Doctor carrying out the examination

8. Doctors Details

Surgery Stamp

Name
Address
E-mail address
Fax number

I certify that I have this day examined:

____

☐ I confirm that I am the Applicant's Registered Medical Practitioner and that I have referred to the applicant's medical history; or

☐ I am not the Applicant's Registered Medical Practitioner however I have referred to the applicant's medical history and their medical notes;

during the Medical Examination. The answers to the aforementioned questions are correct to the best of my knowledge and belief and I consider the applicant ***FIT/UNFIT** to act as a driver of a hackney carriage or private hire vehicle. *(*delete as applicable)*

Signature of qualified and Registered Medical Practitioner:

____

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Applicant's Details

To be completed in the presence of the
Medical Practitioner carrying out the examination

Please make sure that you have printed your name and date of birth on each page before sending this form with your application

9. Your details

Date of Birth: / /

Your full name **Your address**
E-mail address

Home Tel No.

Work/Daytime No.

About your GP/Group Practice

GP/Group name
Address
Telephone
E-mail address
Fax number

10. Applicants Consent

Consent and Declaration

This section **MUST** be completed and must **NOT** be altered in any way.
Please read the following important information carefully then sign the statements below.

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to Authorised Officers for North Lincolnshire Council.

I authorise such Officers of North Lincolnshire Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and Panel members, and to inform my doctor(s) of the outcome of the case where appropriate.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief, they are correct.

"I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."

Signature: ______________________ **Date:**______________________

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