MEDICAL EXAMINATION REPORT
FOR A PRIVATE HIRE/HACKNEY CARRIAGE DRIVER LICENCE

Notes for Applicants

1. The attached Certificate must be received by the Council within 3 months of the Doctor signing it and need only be completed on the:

   - First application for a licence
   - Age 45, and then every 5 years until age 65
   - Age 65, and every year thereafter
   - Any other times when required by the Council

2. Payment for all medical reports is the applicant's responsibility.

3. The Council apply Group 2 medical standards to all applicants/licence holders. More information on Group 2 medical standards can be accessed at www.gov.uk and reading leaflet INF4D .

Notes for Medical Practitioner

1. When completing this medical form and certificate, please have regard to the DVLA's "At a Glance" and the Medical Commission on Accident Prevention booklet "Medical Aspects of Fitness to Drive". The Council apply Group 2 medical standards for suitability to drive licensed vehicles.

2. Applicants who may be symptom free at the time of the examination should be advised that if, in future, they develop symptoms of a condition which could affect safe driving and they hold any type of licence they must inform the Council.

3. The main purpose of the certificate is to ascertain that the client is fit to drive and any additional information should only be disclosed to advise on recommended length of fitness (e.g. insulin dependant diabetic) or workplace adjustments required under the Disability Discrimination Act 1995.

Group 2 Medical Standards

Medical standards for drivers of passenger carrying vehicles are higher than those required for car drivers. The following conditions are likely to be a bar to the holding of a private hire or hackney carriage driver licence:

1. **Epilepsy or liability to epileptic attacks**
   Applicants must have been free of epileptic seizures for at least the last 10 years and have not taken any anti-epilepsy medication during this 10 year period. The Council is likely to refuse or revoke a licence if these conditions cannot be met.

2. **Diabetes**
   Applicants with insulin treated diabetes may **NOT** obtain a licence to be a Private Hire or Hackney Carriage Driver **UNLESS** they held a Private Hire or Hackney Carriage Driver Licence valid on 1 April 1991 and the Council had knowledge of the insulin treatment before 1 January 1991.

3. Eyesight

All applicants must be able to read in good a registration mark fixed to a vehicle registered under current standards at a distance of 20 metres with letters and numbers 79 mm high by 50 mm wide on a car registered since 1 September 2001 or at a distance of 20.5 metres with letters and numbers 79 mm high by 57 mm wide on a car registered before 1 September 2001 and the visual acuity must be at least Snellen 6/12 or better.

In addition applicants must have:

- A visual acuity of at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye.
- A visual acuity of at least 6/60 (decimal Snellen equivalent 0.1) in the worse eye.
- This may be achieved with or without glassess or contact lenses.
- If glasses (not contact lenses) are worn for driving, the spectacle prescription of either lens used must not be of a corrective power greater than plus 8 (+8) dioptres in any meridian.

Applicants are also barred from holding a licence if they have:

- Uncontrolled diplopia (double vision)
- Or do not have a normal binocular field of vision.

4. Other medical conditions

In addition applicants are likely to be refused a licence if they are unable to meet thr national recommended guidelines in the following cases:

- Within three months of myocardial infarction, an episode of unstable angina, CABG or coronary angioplasty.
- A significant disturbance of cardiac rhythm occurring within the past five years unless special criteria are met.
- Suffering from or receiving medication for angina or heart failure.
- Hypertension where the blood pressure is persistently 180 systolic or more and/or 100 diastolic or more.
- A stroke or TIA within the last twelve months.
- Unexplained loss of consciousness within the past five years.
- Meniere's and other conditions causing disabling vertigo within the past twelve months aand with a liability to recurrence.
- Recent severe head injury with serious continuing after effects or major brain surgery.
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders with symptoms likely to affect limb power and co-ordination.
- Suffering from a psychotic illness in the past three years or suffering from dementia.
- Alcohol dependency or miuse or persistent drug or substance misuse or dependency in the past three years.
- Insuperable difficulty in communiction by telehone in an emergency.
- If major psychotropic or neuroleptic medication is being taken.
- Any malignant condition within the last two years likely to metastasise to the brain.
- Any other serious medical condition likely to affect the safe driving of a passenger carrying vehicle.

SECTION A

Applicant's Details

Surname:	**Age:**
Forename(s):	**Date of Birth:**
	Home Tel No:
Address:	**Mobile No:**
Post Code:	

Applicant's Registered Doctor's Details

GP/Practice Name:
Address:
Telephone Number:
E mail address:

SECTION B

Driver & Vehicle Licensing Agency

Medical examination report

Vision assessment

To be filled in by a doctor or optician/optometrist

D4

If correction is needed to meet the eyesight standard for driving, all questions must be answered. If correction is not needed, questions 5 and 6 can be ignored.

1. Please confirm (✓) the scale you are using to express the driver's visual acuities.

Snellen ☐ Snellen expressed as a decimal ☐

LogMAR ☐

2. Please state the visual acuity of each eye (see INF4D).

Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

Uncorrected		Corrected (using prescription worn for driving)	
R	L	R	L

3. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard)? **Yes** ☐ **No** ☐

4. Were corrective lenses worn to meet this standard? **Yes** ☐ **No** ☐

If **Yes**, glasses ☐ contact lenses ☐ both together ☐

5. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? **Yes** ☐ **No** ☐

6. If correction is worn for driving, is it well tolerated? **Yes** ☐ **No** ☐

If **No**, please give full details in the box provided

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? **Yes** ☐ **No** ☐

If formal visual field testing is considered necessary, DVLA will commission this at a later date

8. Is there diplopia? **Yes** ☐ **No** ☐

(a) If **Yes**, is it controlled? ☐ ☐

If **Yes**, please give full details in the box provided

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision that impairs their ability to drive? **Yes** ☐ **No** ☐

10. Does the applicant have any other ophthalmic condition? **Yes** ☐ **No** ☐

If **Yes** to any of questions 7-10, please give full details in the box provided.

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature D D M M Y Y

Please provide your GOC or GMC number

Doctor/optometrist/optician's stamp

Applicant's full name _____ **Date of birth** D D M M Y Y

Please do not detach this page

Driver & Vehicle Licensing Agency

Medical examination report
Medical assessment
Must be filled in by a doctor

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant and take the applicant's history.

D4

1 Neurological disorders

Please tick ✓ the appropriate box(es)

Is there a history of, or evidence of **any** neurological disorder? **Yes** ☐ **No** ☐

If **No**, go to section **2**
If **Yes**, please answer **all** the questions below, give details in section 6, page 6 and enclose relevant hospital notes.

		Yes	No
1.	Has the applicant had any form of seizure?	☐	☐
	(a) Has the applicant had more than one attack?	☐	☐
	(b) Please give date of first and last attack		
	First attack D D M M Y Y		
	Last attack D D M M Y Y		
	(c) Is the applicant currently on anti-epileptic medication?	☐	☐
	If **Yes,** please fill in current medication in **section 8, page 7**		
	(d) If no longer treated, please give date when treatment ended D D M M Y Y		
	(e) Has the applicant had a brain scan?	☐	☐
	If **Yes,** please give details in **section 6, page 6**		
	(f) Has the applicant had an EEG?	☐	☐
	If **Yes** to any of above, please supply reports if available.		
2.	Stroke or TIA?	☐	☐
	If **Yes,** please give date D D M M Y Y		
	Has there been a **FULL** recovery?	☐	☐
	Has a carotid ultrasound been undertaken?	☐	☐
	If **Yes**, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
3.	Sudden and disabling dizziness/vertigo within the last year with a liability to recur?	☐	☐
4.	Subarachnoid haemorrhage?	☐	☐
5.	Serious traumatic brain injury within the last 10 years?	☐	☐
6.	Any form of brain tumour?	☐	☐
7.	Other brain surgery or abnormality?	☐	☐
8.	Chronic neurological disorders?	☐	☐
9.	Parkinson's disease?	☐	☐
10.	Is there a history of blackout or impaired consciousness within the last 5 years?	☐	☐
11.	Does the applicant suffer from narcolepsy?	☐	☐

2 Diabetes mellitus

		Yes	No
	Does the applicant have diabetes mellitus?	☐	☐
	If **No**, go to section 3, page 4		
	If **Yes**, please answer **all** the questions below.		
1.	Is the diabetes managed by:	Yes	No
	(a) Insulin?	☐	☐
	If **Yes**, please give date started on insulin D D M M Y Y		
	(b) If treated with insulin, are there at least 3 continuous months of blood glucose readings stored on a memory meter(s)?	☐	☐
	If **No**, please give details in **section 6, page 6**		
	(c) Other injectable treatments?	☐	☐
	(d) A Sulphonylurea or a Glinide?	☐	☐
	(e) Oral hypoglycaemic agents and diet?	☐	☐
	If **Yes** to any of (a)-(e), please fill in current medication in **section 8, page 7**		
	(f) Diet only?	☐	☐
2.	(a) Does the applicant test blood glucose at least twice every day?	Yes ☐	No ☐
	(b) Does the applicant test at times relevant to driving **(no more than 2 hours before the start of the first journey and every 2 hours while driving)?**	☐	☐
	(c) Does the applicant keep fast acting carbohydrate within easy reach when driving?	☐	☐
	(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐
3.	Is there any evidence of impaired awareness of hypoglycaemia?	Yes ☐	No ☐
4.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	Yes ☐	No ☐
	If **Yes**, please give dates and details in **section 6**		
5.	Is there evidence of:	Yes	No
	(a) Loss of visual field?	☐	☐
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
	If **Yes** to any of 4-5 above, please give details in **section 6, page 6**		
6.	Has there been laser treatment or intra-vitreal treatment for retinopathy?	Yes ☐	No ☐
	If **Yes**, please give date(s) of treatment.		

Applicant's full name _____ **Date of birth** D D M M Y Y

3 Cardiac

a Coronary artery disease

Is there a history of, or evidence of, coronary artery disease? Yes ☐ No ☐

If **No,** go to **section 3b**

If **Yes,** please answer **all** questions below and give details at **section 6** of the form and enclose relevant hospital notes.

1. Has the applicant suffered from angina? Yes ☐ No ☐
   If **Yes**, please give the date of the last known attack D D M M Y Y
2. Acute coronary syndrome including myocardial infarction? Yes ☐ No ☐
   If **Yes**, please give date D D M M Y Y
3. Coronary angioplasty (PCI)? Yes ☐ No ☐
   If **Yes**, please give date of most recent intervention D D M M Y Y
4. Coronary artery bypass graft surgery? Yes ☐ No ☐
   If **Yes**, please give date D D M M Y Y
5. If **Yes** to any of the above, are there any physical health problems (e.g. mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Yes ☐ No ☐

b Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? Yes ☐ No ☐

If **No**, go to **section 3c**

If **Yes**, please answer **all** questions below and give details in **section 6, page 6** and enclose relevant hospital notes.

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 the last 5 years? Yes ☐ No ☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes ☐ No ☐
3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted? Yes ☐ No ☐
4. Has a pacemaker been implanted? Yes ☐ No ☐
   If **Yes:**
   (a) Please give date of implantation D D M M Y Y
   (b) Is the applicant free of the symptoms that caused the device to be fitted? ☐ ☐
   (c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection? Yes ☐ No ☐

If **No**, go to **section 3d**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6,** and enclose relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease) Yes ☐ No ☐
2. Does the applicant have claudication? Yes ☐ No ☐
   If **Yes,** how long in minutes can the applicant walk at a brisk pace before being symptom-limited?
   Please give details
3. Aortic aneurysm? Yes ☐ No ☐
   If **Yes:**
   (a) Site of aneurysm: Thoracic ☐ Abdominal ☐
   (b) Has it been repaired successfully? ☐ ☐
   (c) Is the transverse diameter **currently** > 5.5 cm? ☐ ☐
   If **No**, please provide latest measurement and date obtained
   D D M M Y Y
4. Dissection of the aorta repaired successfully? Yes ☐ No ☐
   If **Yes**, please provide copies of all reports to include those dealing with any surgical treatment.
5. Is there a history of Marfan's disease? Yes ☐ No ☐
   If **Yes**, please provide relevant hospital notes

d Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? Yes ☐ No ☐

If **No**, go to **section 3e**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6** and enclose relevant hospital notes.

1. Is there a history of congenital heart disease? Yes ☐ No ☐
2. Is there a history of heart valve disease? Yes ☐ No ☐
3. Is there a history of aortic stenosis? Yes ☐ No ☐
   If **Yes**, please provide relevant reports
4. Is there any history of embolism? (**not** pulmonary embolism) Yes ☐ No ☐
5. Does the applicant currently have significant symptoms? Yes ☐ No ☐
6. Has there been any progression since the last licence application? (if relevant) Yes ☐ No ☐

Applicant's full name **Date of birth** D D M M Y Y

e Cardiac other

Is there a history of, or evidence of heart failure? Yes ☐ No ☐

If **No,** go to **section 3f**

If **Yes,** please answer **all** questions and enclose relevant hospital notes.

1. Established cardiomyopathy? Yes ☐ No ☐
2. Has a left ventricular assist device (LVAD) been implanted? Yes ☐ No ☐
3. A heart or heart/lung transplant? Yes ☐ No ☐
4. Untreated atrial myxoma? Yes ☐ No ☐

f Cardiac channelopathies

Is there a history of, or evidence of either of the following conditions? Yes ☐ No ☐

If **No**, go to **section 3g** Yes ☐ No ☐

1. Brugada syndrome? Yes ☐ No ☐
2. Long QT syndrome? Yes ☐ No ☐

If **Yes** to either, please give details in section 6 and enclose relevant hospital notes.

g Blood pressure

If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's **best resting** blood pressure reading ☐
2. Is the applicant on anti-hypertensive treatment? Yes ☐ No ☐

   If **Yes**, please provide three previous readings with dates if available

   ☐ D D M M Y Y

   ☐ D D M M Y Y

   ☐ D D M M Y Y
3. Is there a history of malignant hypertension? Yes ☐ No ☐

   If **Yes**, please provide details in section 6 (including date of diagnosis and any treatment etc)

h Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes ☐ No ☐

If **No,** go to **section 4**

If **Yes,** please answer questions 1-6 Yes ☐ No ☐

1. Has a resting ECG been undertaken? Yes ☐ No ☐

   If **Yes**, does it show:

   (a) pathological Q waves? Yes ☐ No ☐

   (b) left bundle branch block? Yes ☐ No ☐

   (c) right bundle branch block? Yes ☐ No ☐

   If **Yes** to a, b or c please provide a copy of the relevant ECG report or comment at **section 6, page 6**.
2. Has an exercise ECG been undertaken (or planned)? Yes ☐ No ☐

   If **Yes**, please give date D D M M Y Y and give details in **section 6, page 6**

   Please provide relevant reports if available
3. Has an echocardiogram been undertaken (or planned)? Yes ☐ No ☐

   (a) If **Yes**, please give date D D M M Y Y and give details in **section 6, page 6**.

   (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? Yes ☐ No ☐

   Please provide relevant reports if available
4. Has a coronary angiogram been undertaken (or planned)? Yes ☐ No ☐

   If **Yes**, please give date D D M M Y Y and give details in **section 6, page 6**.

   Please provide relevant reports if available
5. Has a 24 hour ECG tape been undertaken (or planned)? Yes ☐ No ☐

   If **Yes**, please give date D D M M Y Y and give details in **section 6, page 6**.

   Please provide relevant reports if available
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? Yes ☐ No ☐

   If **Yes**, please give date D D M M Y Y and give details in **section 6, page 6**.

   Please provide relevant reports if available

4 Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years? Yes ☐ No ☐

If **No**, go to **section 5**

If **Yes**, please answer **all** questions below

1. Significant psychiatric disorder within the past 6 months? Yes ☐ No ☐
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes ☐ No ☐
3. Dementia or cognitive impairment? Yes ☐ No ☐
4. Persistent alcohol misuse in the past 12 months? Yes ☐ No ☐
5. Alcohol dependence in the past 3 years? Yes ☐ No ☐
6. Persistent drug misuse in the past 12 months? Yes ☐ No ☐
7. Drug dependence in the past 3 years Yes ☐ No ☐

If 'Yes' to any questions above, please provide full details in section 6, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

Applicant's full name ☐ **Date of birth** D D M M Y Y

5 General

All questions must be answered. If **Yes** to any, give full details in section 6 and enclose relevant hospital notes.

1. Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? **Yes** ☐ **No** ☐

   If **Yes**, please give diagnosis

   a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity

   Mild (AHI <15) ☐

   Moderate (AHI 15 - 29) ☐

   Severe (AHI >29) ☐

   Not known ☐

   If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 6.

   b) Please answer questions (i) – (vi) for **all** sleep conditions

   (i) Date of diagnosis D D M M Y Y **Yes** ☐ **No** ☐

   (ii) Is it controlled successfully? ☐ ☐

   (iii) If **Yes**, please state treatment

   Yes ☐ **No** ☐

   (iv) Is applicant compliant with treatment? ☐ ☐

   (v) Please state period of control

   (vi) Date of last review D D M M Y Y

2. Is there **currently** any functional impairment that is likely to affect control of the vehicle? **Yes** ☐ **No** ☐

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? **Yes** ☐ **No** ☐

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? **Yes** ☐ **No** ☐

5. Is the applicant profoundly deaf? **Yes** ☐ **No** ☐

   If **Yes**, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone? ☐ ☐

6. Does the applicant have a history of liver disease of any origin? **Yes** ☐ **No** ☐

   If **Yes,** please give details in **section 6**

7. Is there a history of renal failure? **Yes** ☐ **No** ☐

   If **Yes,** please give details in **section 6**

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? **Yes** ☐ **No** ☐

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? **Yes** ☐ **No** ☐

   If **Yes**, please provide details of medication and symptoms in **section 6**

10. Does the applicant have any other medical condition that could affect safe driving? **Yes** ☐ **No** ☐

    If **Yes**, please provide details in **section 6**

6 Further details

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

Applicant's full name **Date of birth** D D M M Y Y

7 Consultants' details

Details of type of specialist(s)/consultants, including address.

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

8 Medication

Please provide details of all current medication (continue on a separate sheet if necessary)

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

9 Additional information

Patient's weight (kg)	
Height (cms)	
Details of smoking habits, if any	
Number of alcohol units taken each week	

10 Examining doctor's signature and stamp

To be completed by the doctor carrying out the examination.

Please ensure all sections of the form have been completed. The form will be returned to you if you don't do this.

I confirm that this report was completed by me at examination. I also confirm that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside of the UK.

Signature of practitioner

Date of signature D D M M Y Y

Doctor's stamp

Applicant's full name **Date of birth** D D M M Y Y

CERTIFICATE OF FITNESS TO DRIVE
A PRIVATE HIRE OR HACKNEY CARRIAGE VEHICLE

Applicant Name: _____

Date of Birth: _____

Being a registered Medical Practitioner who is competent in undertaking DVLA Group 2 medical examinations, I have today examined the above applicant. I have examined the applicant medically to DVLA Group 2 medical standards and having regard to the DVLA's "At a Glance" and the Medical Commission on Accident Preventions booklet "Medical Aspects of Fitness to Drive" I consider the above applicant *;

**Please tick relevant box*

☐ Is **FIT** to drive a Private Hire or Hackney Carriage Vehicle to Group 2 Standards

☐ Is **UNFIT** to drive a Private Hire or Hackney Carriage Vehicle

The following additional information is to be disclosed to the Licensing Authority (see page 1 note B) in relation to any form of workplace adjustments under the Disability Discrimination Act and / or the period of an applicants fitness to drive (e.g. insulin dependent diabetic).

_____

_____

(Any additional information not relevant to the above two instances must not be disclosed. The Medical Practitioner must determine from the medical completed whether the applicant is or is not fit to drive under Group 2 standards)

EXAMINING DOCTORS DETAILS

Name: _____

Surgery Address: _____

_____

Phone: _____ **Email**: _____

Signed: _____ **Date:** _____

GMC Registration Number:

Surgery Stamp: