



# GROUP 2 MEDICAL ASSESSMENT

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

**IMPORTANT: ASSESSMENTS MUST NOT TAKE PLACE MORE THAN TWO CALENDAR MONTHS BEFORE THE DATE A LICENCE IS GRANTED OR RENEWED.  
APPLICANTS ONLY NEED TO RETURN PAGES 1 AND 2 OF THIS MEDICAL TO LICENSING**

**Applicant's Details: (to be completed in the presence of the GP or Doctor carrying out the examination)**

Full name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

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**

Signed: \_\_\_\_\_

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

The applicant has provided me the following form of identification:

Driving Licence  Passport  Birth Certificate  HM Forces ID Card

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.

**Medical certification frequency requirement**

- A new certificate must be produced every 5 years after the applicant's 45<sup>th</sup> 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 \_\_\_\_\_

Please add address and phone number  
or Medical Practice Address Stamp  
No disclaimers are acceptable.

**PLEASE ENSURE YOU COMPLETE AND SIGN THE ADDITIONAL INFORMATION PAGE OVERLEAF**

Additional Information

Please note any relevant medical information about the applicant here that would normally be noted in section 7 of the standard Group 2 Medical form.

## Section 1

**Vision Assessment – to be completed by the GP or Optician/Optomtrist**

Please see the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at [www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals](http://www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals)

1	Please confirm the scale you are using to express the driver's visual acuities: <input type="checkbox"/> Snellen <input type="checkbox"/> Snellen expressed as a decimal <input type="checkbox"/> LogMAR					
					<b>YES</b>	<b>NO</b>
2	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)				<input type="checkbox"/>	<input type="checkbox"/>
3	Were corrective lenses worn to meet this standard? If <b>Yes</b> please indicate if: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Both				<input type="checkbox"/>	<input type="checkbox"/>
4	<b>Uncorrected</b>		<b>Corrected (using the prescription worn for driving)</b>			
	Right	<input type="text"/>	Left	<input type="text"/>	Right	<input type="text"/>
5	If <b>glasses</b> (not contact lenses) are worn for driving, is the corrective power greater than +8 dioptres in any meridian of either lens?				<input type="checkbox"/>	<input type="checkbox"/>
6	If a correction is worn for driving, is it well tolerated?				<input type="checkbox"/>	<input type="checkbox"/>
7	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and / or peripheral)?				<input type="checkbox"/>	<input type="checkbox"/>
8	Is there diplopia (controlled or uncontrolled)?				<input type="checkbox"/>	<input type="checkbox"/>
9	Does the applicant, on questioning, report symptoms of intolerance to glare and / or impaired contrast sensitivity and / or impaired twilight vision?				<input type="checkbox"/>	<input type="checkbox"/>
10	Does the applicant have any other ophthalmic condition?				<input type="checkbox"/>	<input type="checkbox"/>

If **YES** to questions 7, 8, 9 or 10 please give details in the **Additional Information** section.

If eye examination has been completed by an Optician or Optometrist please give details below:

Name:

Address:

Contact telephone number:

## Section 2

**NERVOUS SYSTEM**

	Is there any history of, or evidence of, <b>any</b> neurological disorder? If <b>No</b> , go to section 3				<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
1	Has the applicant had any form of seizure? If <b>YES</b> please answer questions a – f below.				<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
a	Has the applicant had more than one attack?				<input type="checkbox"/>	<input type="checkbox"/>
b	Please give date of first and last attack:	<i>First attack</i>	DD MM YY	<i>Last attack</i>	DD MM YY	
c	Is the applicant currently on anti-epileptic medication? If <b>YES</b> please give details of current medication in the <b>Additional Information</b> section.				<input type="checkbox"/>	<input type="checkbox"/>
d	If no longer treated, please give date when treatment ended.			DD MM YY		
e	Has the applicant had a brain scan? If <b>YES</b> please provide date and details in the <b>Additional Information</b> section.				<input type="checkbox"/>	<input type="checkbox"/>
f	Has the applicant had an EEG? If <b>YES</b> please provide date and details in the <b>Additional Information</b> section.				<input type="checkbox"/>	<input type="checkbox"/>
2	Is there a history of blackout or impaired consciousness within the last 5 years? If <b>YES</b> please give dates and details in the <b>Additional Information</b> section.				<input type="checkbox"/>	<input type="checkbox"/>
3	Does the applicant suffer from narcolepsy? If <b>YES</b> please give dates and details in the <b>Additional Information</b> section				<input type="checkbox"/>	<input type="checkbox"/>
4	Is there a history of, or evidence of, any of the conditions listed at a – h below? If <b>NO</b> go to <b>Section 3</b> .				<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> please give dates and full details in the <b>Additional Information</b> section.					
a	Stroke / TIA If <b>YES</b> please give date: DD MM YY				<input type="checkbox"/>	<input type="checkbox"/>
	Has there been a <b>FULL</b> recovery?				<input type="checkbox"/>	<input type="checkbox"/>
	Has a carotid ultrasound been undertaken?				<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> , was the carotid artery stenosis >50% in either carotid artery?				<input type="checkbox"/>	<input type="checkbox"/>
b	Sudden and disabling dizziness/vertigo within the last one year with a liability to recur				<input type="checkbox"/>	<input type="checkbox"/>
c	Subarachnoid haemorrhage				<input type="checkbox"/>	<input type="checkbox"/>
d	Serious traumatic brain injury within the last 10 years				<input type="checkbox"/>	<input type="checkbox"/>
e	Any form of brain tumour				<input type="checkbox"/>	<input type="checkbox"/>
f	Other brain surgery or abnormality				<input type="checkbox"/>	<input type="checkbox"/>
g	Chronic neurological disorders				<input type="checkbox"/>	<input type="checkbox"/>
h	Parkinson's disease				<input type="checkbox"/>	<input type="checkbox"/>

## Section 3

**DIABETES MELLITUS**

Does the applicant have diabetes mellitus?

If **NO** please go to Section 4.If **YES** please answer the following questions.**Yes****No**

1	Is the diabetes managed by:-		<input type="checkbox"/>	<input type="checkbox"/>
	a	Insulin? If <b>YES</b> please give date started on insulin: DD MM YY	<input type="checkbox"/>	<input type="checkbox"/>
	b	If treated with insulin, are there at least 3 continuous months of blood glucose readings stored in a memory meter? If <b>NO</b> , please give details in the <b>Additional Information</b> section.	<input type="checkbox"/>	<input type="checkbox"/>
	c	Other injectable treatments?	<input type="checkbox"/>	<input type="checkbox"/>
	d	A Sulphonylurea or a Glinide?	<input type="checkbox"/>	<input type="checkbox"/>
	e	Oral hypoglycaemic agents and diet? If <b>YES</b> please provide details of medication:	<input type="checkbox"/>	<input type="checkbox"/>
	f	Diet only?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> to any of (a) – (e) above, please give details in the <b>Additional Information</b> section.				
2	a	Does the applicant test blood glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>
	b	Does the applicant test at times relevant to driving?	<input type="checkbox"/>	<input type="checkbox"/>
	c	Does the applicant keep fast acting carbohydrate within easy reach when driving?	<input type="checkbox"/>	<input type="checkbox"/>
	d	Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
3	Is there any evidence of impaired awareness of hypoglycaemia?		<input type="checkbox"/>	<input type="checkbox"/>
4	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?		<input type="checkbox"/>	<input type="checkbox"/>
5	Is there evidence of:-			
	a	Loss of visual field?	<input type="checkbox"/>	<input type="checkbox"/>
	b	Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> to any or 3 – 5 above, please give details in the <b>Additional Information</b> section.				
6	Has there been any laser treatment or intra-vitreal for retinopathy? If <b>YES</b> please give date(s) of treatment: DD MM YY		<input type="checkbox"/>	<input type="checkbox"/>

## Section 4

**CARDIAC****4A CORONARY ARTERY DISEASE**

Is there a history of, or evidence of, Coronary Artery Disease? If <b>NO</b> please go to Section 4B. If <b>YES</b> please answer all questions below and give details in the <b>Additional Information</b> section.		Yes <input type="checkbox"/>	No <input type="checkbox"/>
1	Acute coronary syndrome including myocardial infarction? If <b>YES</b> please give date(s): DD MM YY	<input type="checkbox"/>	<input type="checkbox"/>
2	Coronary artery by-pass graft surgery? If <b>YES</b> please give date(s): DD MM YY	<input type="checkbox"/>	<input type="checkbox"/>
3	Coronary Angioplasty (PCI)? If <b>YES</b> please give date of most recent intervention: DD MM YY	<input type="checkbox"/>	<input type="checkbox"/>
4	Has the applicant suffered from angina? If <b>YES</b> please give the date of the last known attack: DD MM YY	<input type="checkbox"/>	<input type="checkbox"/>
5	If <b>YES</b> to any of the above, are there any physical health problems (eg. Mobility/arthritis. COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?	<input type="checkbox"/>	<input type="checkbox"/>

**4B CARDIAC ARRHYTHMIA**

Is there a history of, or evidence of, cardiac arrhythmia? If <b>NO</b> , go to Section 4C If <b>YES</b> please answer all questions below and give details in the <b>Additional Information</b> section.		Yes <input type="checkbox"/>	No <input type="checkbox"/>
1	Has there been a <b>significant</b> disturbance of cardiac rhythm? i.e. Sinus node disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia, in last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
2	Has the arrhythmia been controlled satisfactorily for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
3	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4	Has a pacemaker been implanted? If <b>YES</b> :	<input type="checkbox"/>	<input type="checkbox"/>
a	Please supply date:		
b	Is the applicant free of symptoms that caused the device to be fitted?	<input type="checkbox"/>	<input type="checkbox"/>
c	Does the applicant attend a pacemaker clinic regularly?	<input type="checkbox"/>	<input type="checkbox"/>

4C		PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION		
Is there a history or evidence of <b>ANY</b> of the conditions listed at 1 – 5 below? If <b>NO</b> go to Section 4D. If <b>YES</b> please answer the questions below and give details in the <b>Additional Information</b> section			Yes <input type="checkbox"/>	No <input type="checkbox"/>
1	Peripheral Arterial Disease (excluding Buerger's Disease)		<input type="checkbox"/>	<input type="checkbox"/>
2	Does the applicant have claudication? If <b>YES</b> , how long in minutes can the applicant walk at a brisk pace before being symptom limited?:		<input type="checkbox"/>	<input type="checkbox"/>
3	Aortic Aneurysm If <b>YES</b> :		<input type="checkbox"/>	<input type="checkbox"/>
	a	Site of Aneurysm (please tick):	Thoracic <input type="checkbox"/>	Abdominal <input type="checkbox"/>
	b	Has it been repaired successfully?		<input type="checkbox"/>
	c	Is the transverse diameter <b>currently</b> >5.5cm?		<input type="checkbox"/>
		If <b>NO</b> please provide latest measurement:		Date obtained: DD MM YY
4	Dissection of the Aorta repaired successfully. If <b>YES</b> , please provide details in the <b>Additional Information</b> section.		<input type="checkbox"/>	<input type="checkbox"/>
5	Is there history of Marfan's disease? If <b>YES</b> , please provide details in the <b>Additional Information</b> section.		<input type="checkbox"/>	<input type="checkbox"/>
4D		VALVULAR/CONGENITAL HEART DISEASE		
Is there a history of, or evidence of, valvular/congenital heart disease?			Yes <input type="checkbox"/>	No <input type="checkbox"/>
If <b>NO</b> go to Section 4E. If <b>YES</b> please answer all questions below and give details in the <b>Additional Information</b> section.				
1	Is there a history of congenital heart disorder?		<input type="checkbox"/>	<input type="checkbox"/>
2	Is there a history of heart valve disease?		<input type="checkbox"/>	<input type="checkbox"/>
3	Is there a history of aortic stenosis?		<input type="checkbox"/>	<input type="checkbox"/>
4	Is there any history of embolism? (not pulmonary embolism)		<input type="checkbox"/>	<input type="checkbox"/>
5	Does the applicant currently have significant symptoms?		<input type="checkbox"/>	<input type="checkbox"/>
6	Has there been any progression since the last licence application? (if relevant)		<input type="checkbox"/>	<input type="checkbox"/>
4E		CARDIAC OTHER		
Does the applicant have a history of <b>ANY</b> of the following conditions? If <b>NO</b> go to Section 4F. If <b>YES</b> please answer <b>ALL</b> questions below and give details in the <b>Additional Information</b> section.			Yes <input type="checkbox"/>	No <input type="checkbox"/>
a	A history of, or evidence of, heart failure?		<input type="checkbox"/>	<input type="checkbox"/>
b	Established cardiomyopathy?		<input type="checkbox"/>	<input type="checkbox"/>
c	Has a left ventricular assist device (LVAD) been implanted?		<input type="checkbox"/>	<input type="checkbox"/>
d	A heart or heart/lung transplant?		<input type="checkbox"/>	<input type="checkbox"/>
e	Untreated atrial myxoma?		<input type="checkbox"/>	<input type="checkbox"/>

4F		CARDIAC CHANNELOPATHIES	
Is there a history of, or evidence of either of the following conditions? If <b>No</b> , go to section 4G		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
1	Brugada syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
2	Long QT syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> to either, please give details in the <b>Additional Information</b> section			
4G		BLOOD PRESSURE (This section must be filled in for all applicants)	
1	Please record today's <b>best resting</b> blood pressure reading:		
2	Is the applicant on anti-hypertensive treatment?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
If <b>YES</b> please provide three previous readings with dates if available:			
1	B.P. reading:	Date: DD MM YY	
2	B.P. reading:	Date: DD MM YY	
3	B.P. reading:	Date: DD MM YY	
3	Is there history of malignant hypertension? If <b>Yes</b> , please provide details in the <b>Additional Information</b> section (including date of diagnosis and any treatment etc)	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
4H		CARDIAC INVESTIGATIONS (This section must be filled in for all applicants)	
Have any cardiac investigations been undertaken or planned? If <b>No</b> , go to section 5 If <b>Yes</b> , please answer questions 1 - 6		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
1	Has a resting ECG been undertaken? If <b>YES</b> does it show:	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
a	Pathological Q waves?	<input type="checkbox"/>	<input type="checkbox"/>
b	Left bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
c	Right bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> to a, b or c please provide details in the <b>Additional Information</b> section			
2	Has the exercise ECG been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> please provide date and give details in the <b>Additional Information</b> section DD MM YY			
3	Has an echocardiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
a	If <b>YES</b> please give date and give details in the <b>Additional Information</b> section DD MM YY		
b	If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?	<input type="checkbox"/>	<input type="checkbox"/>



4	Has a coronary angiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> please provide date and give details in the <b>Additional Information</b> section:	DD MM YY	
5	Has a 24 hour ECG tape been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> please provide date and give details in the <b>Additional Information</b> section	DD MM YY	
6	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> please provide date and give details in the <b>Additional Information</b> section	DD MM YY	

<b>Section 5</b>
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<b><u>PSYCHIATRIC ILLNESS</u></b>
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Is there a history of, or evidence of <b>ANY</b> of the conditions listed at 1 – 9 below?	<b>Yes</b>	<b>No</b>
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If <b>NO</b> please go to Section 6.	<input type="checkbox"/>	<input type="checkbox"/>
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If <b>YES</b> please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in the <b>Additional Information</b> section. (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in the <b>Additional Information</b> section).		
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1	Significant psychiatric disorder within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
2	Psychosis or hypomania/mania within the past 3 years, including psychotic depression?	<input type="checkbox"/>	<input type="checkbox"/>
3	Dementia or cognitive impairment?	<input type="checkbox"/>	<input type="checkbox"/>
4	Persistent alcohol misuse in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5	Alcohol dependence in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
6	Does the applicant show any evidence of being addicted to the excessive use of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
7	Persistent drug misuse in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8	Does the applicant show any evidence of being addicted to the excessive use of drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9	Drug dependency in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>

## Section 6

**GENERAL**

Please answer all questions in this section. If your answer is **YES** to any question please give full details in the **Additional Information** section.

1	Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
	If <b>YES</b> please give diagnosis:		
a	<p>If Obstructive Sleep Apnoea Syndrome, please indicate the severity</p> <p>Mild (AHI&lt;15) <input type="checkbox"/></p> <p>Moderate (AHI 15 – 29) <input type="checkbox"/></p> <p>Severe (AHI &gt;29) <input type="checkbox"/></p> <p>Not known <input type="checkbox"/></p> <p>If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. Please give details in the <b>Additional Information</b> section.</p>		
b	Please answer questions (i) to (vi) for <b>all</b> sleep conditions		
(i)	Date of diagnosis: DD MM YY		
(ii)	Is it controlled successfully?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
(iii)	If <b>Yes</b> please state treatment:		
(iv)	Is patient compliant with treatment	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
(v)	Please state period of control:		
(vi)	Date of last review: DD MM YY		
2	Is there <b>currently</b> any functional impairment that is likely to affect control of the vehicle?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
3	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
4	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
5	Is the applicant profoundly deaf?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
	If <b>YES</b> is the applicant able to communicate in the event of an emergency by speech or by using a device, eg. a textphone?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
6	Does the applicant have a history of liver disease of any origin? If <b>YES</b> please provide details in the <b>Additional Information</b> section.	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
7	Is there any history of renal failure? If <b>YES</b> please provide details in the <b>Additional Information</b> section.	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
8	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
9	Does any medication currently taken cause the applicant side effects that could affect safe driving?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>

	If <b>YES</b> please provide details of medication and symptoms in the <b>Additional Information</b> section.		
10	Does the applicant have any other medical condition that could affect safe driving? If <b>YES</b> please provide details in the <b>Additional Information</b> section.	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>