Checked by (Officer initials):	
Date Received:	
Licence/APP Ref No:	

MEDICAL EXAMINATION REPORT GROUP 2 LICENCE ENTITLEMENT FOR HACKNEY CARRIAGE AND PRIVATE HIRE DRIVERS

PRESTON CITY COUNCIL
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VERSION DATE 30th September 2024

GROUP 2 MEDICAL EXAMINATION REPORT FORM

Guidance for applicants for a private hire / hackney carriage driver's licence

When is a medical required?

- All applications for a hackney carriage and / or private hire driver's licence must be accompanied by a satisfactory medical report to the **DVLA Group 2 medical standards**. This is regardless of the age of the applicant.
- A medical will be required on submission of a new application and every 3 years thereafter (on renewal), until the age of 65. From age 65 onwards a medical will be required annually.
- Some medical conditions will need an annual medical certificate or an annual letter from a Doctor indicating that a current medical condition is under control and remains stable.

*Please check that this medical examination report form ("this form") is the most **recent version** by visiting the following web address and checking the version date: www.preston.gov.uk/taxidriver. Information about the Group 2 medical standards can be found in the DVLA's leaflet '**INF4D**'.

Completion of this form

This form is based on the DVLA D4 medical examination form for a Group 2 licence. The medical must be completed by a GP (Doctor) that has access to the applicant's medical record.

This form should be completed in block capitals using **black ink**. The applicant must complete sections 13 and 14 of this form in front of the GP (Doctor) who is carrying out the medical assessment.

Guidance for the GP (Doctor) completing this form

Please check the applicant's identity before you proceed with the medical assessment and specify the type of identification provided by the applicant on page 8 of this form. Also, complete the applicant's full name and date of birth at the bottom of each page to this form. Please answer all questions, including sections 11 and 12. Please ensure you **fully examine** the applicant as well as taking the applicant's history.

The medical assessment includes a **vision assessment**. If you are unable to fully answer the vision assessment questions the applicant must have this part of the medical completed by an optician or optometrist.

Applicant's Full Name: _____

Applicant's Date of Birth: DD/MM/YYYY

Medical examination report

Vision assessment

To be filled in by an optician, optometrist or doctor

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

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other.

(a) Please provide uncorrected visual acuities for each eye. 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.

R ☐ L ☐

	Yes	No
(b) Are corrective lenses worn for driving? **If No, go to Q3.**	☐	☐

If Yes, please provide the visual acuities using the correction worn for driving. 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.

R ☐ L ☐

(c) What kind of corrective lenses are worn to meet this standard?

Glasses ☐ Contact lenses ☐ Both together ☐

	Yes	No
(d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?	☐	☐
(e) If correction is worn for driving, is it well tolerated? If No, please give full details in Q7.	☐	☐

3. 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 Yes, please give full details below.

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

4. Is there diplopia? Yes ☐ No ☐

(a) Is it controlled? ☐ ☐

Please indicate below and give full details in Q7.

Patch or glasses with frosted glass ☐ Glasses with/without prism ☐ Other (if other please provide details) ☐

5. Does the applicant report symptoms of any of the following that impairs their ability to drive? Yes ☐ No ☐

Please indicate below and give full details in Q7 below.

(a) Intolerance to glare (causing incapacity rather than discomfort) and/or ☐

(b) Impaired contrast sensitivity and/or ☐

(c) Impaired twilight vision ☐

6. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? Yes ☐ No ☐

If Yes, please give full details in Q7 below.

7. Details or additional information

Name of examining doctor, optician or optometrist undertaking vision assessment

I confirm that this report was filled in by me at examination and the applicant's history has been taken into consideration.

Signature of examining doctor, optician or optometrist

Date of signature

Please provide your GOC or GMC number

Doctor, optometrist or optician's stamp

Applicant's full name **Date of birth**

Please do not detach this page

Medical examination report

Medical assessment

Must be filled in by a doctor

1 Neurological disorders

Please tick ✓ the appropriate boxes

Is there a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? Yes ☐ No ☐

If No, go to section 2, Diabetes mellitus

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

		Yes	No
1.	Has the applicant had any form of seizure?	☐	☐
	(a) Has the applicant had more than one seizure episode?	☐	☐
	(b) If Yes, please give date of first and last episode.		
	First episode D D M M Y Y		
	Last episode D D M M Y Y		
	(c) Is the applicant currently on anti-epileptic medication? If Yes, please fill in the medication section 8, page 6.	☐	☐
	(d) If no longer treated, when did treatment end? D D M M Y Y		
	(e) Has the applicant had a brain scan? If Yes, please give details in section 9, page 7.	☐	☐
	(f) Has the applicant had an EEG? If you have answered Yes to any of above, you must supply medical reports.	☐	☐
2.	Has the applicant experienced dissociative/'non-epileptic' seizures?	☐	☐
	(a) If Yes, please give date of most recent episode. D D M M Y Y		
	(b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	☐	☐
3.	Stroke or TIA?	☐	☐
	If Yes, give date. D D M M Y Y		
	(a) Has there been a **full** recovery?	☐	☐
	(b) Has a carotid ultrasound been undertaken?	☐	☐
	(c) If Yes, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
	(d) Is there a history of multiple strokes/TIAs?	☐	☐
4.	Sudden and disabling dizziness or vertigo within the last year with a liability to recur?	☐	☐
5.	Subarachnoid haemorrhage (non-traumatic)?	☐	☐
6.	Significant head injury within the last 10 years?	☐	☐
7.	Any form of brain tumour?	☐	☐
8.	Other intracranial pathology?	☐	☐
9.	Chronic neurological disorder(s)?	☐	☐
10.	Parkinson's disease?	☐	☐
11.	Blackout, impaired consciousness or loss of awareness within the last 10 years?	☐	☐

2 Diabetes mellitus

Does the applicant have diabetes mellitus? Yes ☐ No ☐

If No, go to section 3, Cardiac

If Yes, please answer all questions below.

		Yes	No
1.	Is the diabetes managed by:		
	(a) Insulin? If No, go to 1c	☐	☐
	If Yes, please give date started on insulin. D D M M Y Y		
	(b) Are there at least 6 continuous weeks of blood glucose readings stored on a memory meter or meters?	☐	☐
	If No, please give details in section 9, page 7.		
	(c) Other injectable treatments?	☐	☐
	(d) A Sulphonylurea or a Glinide?	☐	☐
	(e) Oral hypoglycaemic agents and diet? If Yes to any of (a) to (e), please fill in the medication section 8, page 6.	☐	☐
	(f) Diet only?	☐	☐
2.	(a) Does the applicant test blood glucose at least twice every day?	☐	☐
	(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.	(a) Has the applicant ever had a hypoglyaemic episode?	☐	☐
	(b) If Yes, is there full awareness of hypoglycaemia?	☐	☐
4.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If Yes, please give details and dates below.	☐	☐
5.	Is there evidence of:		
	(a) Loss of visual field?	☐	☐
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
	If Yes, please give details in section 9, page 7.		
6.	Has there been laser treatment or intra-vitreal treatment for retinopathy?	☐	☐
	If Yes, please give most recent date of treatment. D D M M Y Y		

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

3 Cardiac

a Coronary artery disease

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

If No, go to section 3b, Cardiac arrhythmia

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

1. Has the applicant ever had an episode of 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 or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details below. Yes ☐ No ☐

b Cardiac arrhythmia

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

If No, go to section 3c, Peripheral arterial disease

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

1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or 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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes ☐ No ☐
4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) 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 or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? Yes ☐ No ☐

If No, go to section 3d, Valvular/congenital heart disease

If Yes, please answer all questions below 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, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT? ☐ ☐
3. Aortic aneurysm? Yes ☐ No ☐
   If Yes:
   (a) Site of aneurysm: Thoracic ☐ Abdominal ☐
   (b) Has it been repaired successfully? ☐ ☐
   (c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.
   ☐☐.☐ cm D D M M Y Y
4. Dissection of the aorta repaired successfully? Yes ☐ No ☐
   If Yes, please provide copies of all reports including 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 or evidence of valvular or congenital heart disease? Yes ☐ No ☐

If No, go to section 3e, Cardiac other

If Yes, answer all questions below and provide 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 (including echocardiogram).
4. Is there history of embolic stroke? Yes ☐ No ☐
5. Does the applicant currently have significant symptoms? Yes ☐ No ☐
6. Has there been any progression (either clinically or on scans etc) since the last licence application? Yes ☐ No ☐

e Cardiac other

Is there a history or evidence of heart failure? Yes No
If No, go to section 3f, Cardiac channelopathies
If Yes, please answer all questions and enclose relevant hospital notes.

1. Please provide the NYHA class, if known.
2. Established cardiomyopathy? Yes No
   If Yes, please give details in section 9, page 7.
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No
4. A heart or heart/lung transplant? Yes No
5. Untreated atrial myxoma? Yes No

f Cardiac channelopathies

Is there a history or evidence of the following conditions? Yes No
If No, go to section 3g, Blood pressure

1. Brugada syndrome? Yes No
2. Long QT syndrome? Yes No
   If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.

g Blood pressure

All questions must be answered.
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 give details in section 9, page 7 (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, Psychiatric illness
If Yes, please answer questions 1 to 7.

1. Is there a history of the following: Yes No
   (a) left bundle branch block (LBBB)?
   (b) right bundle branch block (RBBB)?
   If yes to (a) or (b), please provide relevant report(s) or comment in section 9, page 7.

Note: If Yes to questions 2 to 6, please give dates in the boxes provided, give details in section 9, page 7 and provide relevant reports.

2. Has an exercise ECG been undertaken (or planned)? D D M M Y Y Yes No
3. Has an echocardiogram been undertaken (or planned)? D D M M Y Y Yes No
   (a) If undertaken, is or was the left ejection fraction greater than or equal to 40%? Yes No
4. Has a coronary angiogram been undertaken (or planned)? D D M M Y Y Yes No
5. Has a 24 hour ECG tape been undertaken (or planned)? D D M M Y Y Yes No
6. Has a loop recorder been implanted (or planned)? D D M M Y Y Yes No
7. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? D D M M Y Y Yes No

4 Psychiatric illness

Is there a history or evidence of psychiatric illness within the last 3 years? Yes No
If No, go to section 5, Substance misuse
If Yes, please answer all questions below.

1. Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition. Yes No
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No
3. (a) Dementia or cognitive impairment? Yes No
   (b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses? Yes No

5 Substance misuse

Is there a history of drug/alcohol misuse or dependence? Yes No
If No, go to section 6, Sleep disorders
If Yes, please answer all questions below.

1. Is there a history of alcohol dependence in the past 6 years? Yes No
   (a) Is it controlled? Yes No
   (b) Has the applicant undergone an alcohol detoxification programme? Yes No
   If Yes, give date started: D D M M Y Y
2. Persistent alcohol misuse in the past 3 years? Yes No
   (a) Is it controlled? Yes No
3. Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? Yes No
   (a) If Yes, the type of substance misused?
   (b) Is it controlled? Yes No
   (c) Has the applicant undertaken an opiate treatment programme? Yes No
   If Yes, give date started D D M M Y Y

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

6 Sleep disorders

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

If No, go to section 7, Other medical conditions.
If Yes, please give diagnosis and answer all questions below.

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 9 page 7, Further details.

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

(i) Date of diagnosis: D D M M Y Y

(ii) Is it controlled successfully? Yes ☐ No ☐

(iii) If Yes, please state treatment.

(iv) Is applicant compliant with treatment? Yes ☐ No ☐

(v) Please state period of control:

years months

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

7 Other medical conditions

1. Is there a history or evidence of narcolepsy? Yes ☐ No ☐

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? Yes ☐ No ☐

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

If Yes, is this the result of alcohol misuse? ☐ ☐

If Yes, please give details in section 9, page 7.

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

If Yes, please give details in section 9, page 7.

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 fill in section 8, Medication and give symptoms in section 9, page 7.

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

If Yes, please provide details in section 9, page 7.

8 Medication

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

Medication	Dosage
Reason for taking:	
Approximate date started (if known): D D M M Y Y	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): D D M M Y Y	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): D D M M Y Y	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): D D M M Y Y	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): D D M M Y Y	

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

9 Further details

Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the space below to provide any additional information.

10 Consultants' details

Please provide details of type of specialists or consultants, including address.

Consultant in
Reason for attendance
Name
Address

Date of last appointment: D D M M Y Y

Consultant in
Reason for attendance
Name
Address

Date of last appointment: D D M M Y Y

If more consultants seen give details on a separate sheet.

Applicant's full name

Date of birth D D M M Y Y

Sections 11 and 12 to be completed by the GP / Doctor carrying out the examination

11 Additional information

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

12 GP / Doctor's details (please print name and address in capital letters)

- Please ensure all sections of the form have been completed. Failure to do so will result in the form being rejected.

Full Name:	
Address:	
Post Code:	
Telephone:	
Email address:	

Surgery stamp

I confirm that:

1. I am currently GMC registered and licensed to practice in the UK.
2. I have checked the applicant's identity.
3. I had full access to the applicant's medical records at the time of the medical examination.

Applicant's Full Name: _____ Date of Birth: DD/MM/YYYY

ID Provided:

Signature of GP (Doctor)	
Date of examination	DD/MM/YYYY

Sections 13 and 14 to be completed in the presence of the GP / Doctor carrying out the medical examination.

13 Applicant details

Name:		**Date of Birth**	DD/MM/YYYY
Address:		**Tel No.**	
		Mobile No.	
		Email address	
Post Code:			

About your GP (Doctor) / Group Practice

GP (Doctor) Group		**Telephone:**	
Address:		**Email address:**	
Post Code:			

14 Applicant's 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 to confirm the statements below.

Important information about Consent

On occasion, as part of the investigation into your fitness to drive a hackney carriage/private hire vehicle, Preston City Council may require further information from your doctor, specialist, appropriate healthcare professional, optician or optometrist and/or the Councils independent Group 2 Medical Specialist. Only information relevant to the assessment of your fitness to drive will be requested.

CONSENT AND DECLARATION

- **I authorise** my doctor(s), specialist(s), appropriate healthcare professional(s), optician(s) or optometrist(s) to release reports/medical information about my condition, relevant to my fitness to drive, to Preston City Council.
- **I authorise** Preston City Council to disclose such reports/medical information as may be necessary to the investigation of my fitness to drive, to a doctor(s), specialist(s), other appropriate healthcare professionals(s), optician(s), optometrist(s) or occupational health professional(s), or any other name it may be known by, and the Council's Taxi and Miscellaneous Committee.
- **I understand** that it is a criminal offence if I make a false declaration to obtain a hackney carriage or private hire vehicle driver's licence with Preston City Council and can lead to prosecution.
- **I authorise** Preston City Council to inform my doctor(s), specialist(s), other appropriate healthcare profession(s), optician(s) or optometrist(s) of the outcome of my case and release reports/medical information to them**.**
- **I declare** that I have checked the details I have given on the Medical Examination Report and that, to the best of my knowledge and belief, they are correct.

Full Name of Applicant:	
Signature of Applicant:	
Date:	