

Medical Examination Report for Hackney Carriage and Private Hire Drivers

Group II Medical Examination Report Form

Information notes

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act 1976 to provide a Medical Examination Report to the effect that you are physically fit to drive a Public, Private Hire or Contract vehicle.

You are required provide a Medical Examination Report to the effect that you are physically fit to hold a Hackney Carriage / Private Hire Driver Licence and is for the confidential use of the Licensing Authority.

This form must be completed by a GP who has access to the full medical/history of the applicant.

You are required to complete a further Group II Medical Report Form for every Driving Licence renewal (every 3 years) until the age of 65. From the age of 65, a Group II Medical Report Form is required annually.

Any fees charged are payable by the applicant.

- please use this form to record medical examination details
- please complete in block capital letters in black ink

Licensing Officers are not permitted to complete or amend forms on behalf of applicants.

Note

Any existing licensed private hire/hackney carriage driver must immediately inform the Council in writing of any deterioration in health or of any injury that would affect his/her ability to drive. (This is in addition to the requirement of Section 94 of the Road Traffic Act 1988 requiring any driver to notify the Secretary of State of any relevant disability).

Guidance notes

What you have to do:

- Before consulting a GP you may find it helpful to consult the DVLAs Assessing fitness to drive document. This is available for download here: Assessing fitness to drive: a guide for medical professionals https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medicalprofessionals
- 2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your GP/Optician before you arrange for this medical form to be completed as the GP will normally charge you for completing it. In the event of your application being refused, the fee you pay the GP is not refundable. Westmorland and Furness Council has no responsibility for medical fees.
- 3. Fill in Section 10 of this report in the presence of the GP carrying out the examination.



4. Application forms must be submitted together with the Group II Medical Report Form otherwise there may be delays in processing your application.

What the GP has to do:

- 1. Please arrange for the patient to be seen and examined having access to, and regard for, their medical records.
- 2. Please complete Sections 1-9 and 11 of this report. Please ensure the applicant completes Section 10 in your presence. You may find it helpful to consult the DVLAs Assessing fitness to drive document. This is available for download here: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals
- 3. Applicants who may be asymptomatic at the time of the examination are to be advised that, if in future they develop symptoms of a condition which could affect safe driving and they hold either a Hackney Carriage and/or Private Hire driver licence they must immediately inform the Licensing Team at Westmorland and Furness Council. Please record any advice given at Section 6.
- 4. Please ensure that you have completed all Sections within this form. If this report does not bring out important clinical details which may affect the applicant's fitness to drive, please give details in Section 6.

Westmorland and Furness Council Medical Examination Form

Important information for doctors

Please read and follow the information below before deciding if you are able to **fully** and **accurately** fill in the vision assessment. **If you are unable to do this, you must tell the applicant that they will need to ask an optician or optometrist to fill it in.**

We will make a licensing decision based on the information you provide. What you need to assess:

If glasses (not contact lenses) are worn for driving, you MUST be able to establish the dioptre measurement of the correction used. If the correction is greater than +8 dioptres in any meridian of either lens, we may not be able to issue a Group 2 licence.

Applicants (hackney or private hire) must have, as measured by the 6 metre Snellen chart:

- 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 other eye
- this may be achieved with or without glasses or contact lenses
- we cannot accept a Snellen reading shown with a plus (+) or minus (-) e.g. 6/6-2 or 6/9+3
- 3 metre readings must be converted to the 6 metre equivalent

Before you fill in this report, please:

- check the applicant's identity
- read the information leaflet INF4D (Medical examination report). This can be viewed in PDF format at: https://www.gov.uk/reapply-driving-licence-medical-condition

The applicant is responsible for any fee payable for completion of the assessment. Westmorland and Furness Council will not be liable for any costs involved.

Please note that if you complete the vision assessment as well as the medical assessment, you must sign and date both parts of the form.





Medical Examination Report for a Hackney Carriage or Private Hire Licence

If this form is not fully completed we will return it to you and your application will be delayed

Your details (applicant)

Name:	
Address:	
Daytime ph	one number:
Mobile phor	ne number:
Email:	
Date of Birth	ר:

Your doctor's details:

Doctor's na	ame:
Address:	
Phone num	iber:
Email:	

Examining doctor's details: To be completed by the doctor carrying out the examination

Doctor's nar	me:
Address:	
Phone numb	ber:
Email:	
GMC regist	ration number:



Driver & Vehicle Licensing Agency

Medical examination report for a Group 2 (bus or lorry) licence

For advice on how to fill in this form, read the leaflet INF4D available at **www.gov.uk/reapply-driving-licence-medical-condition** Please use black ink when you fill in this report.

Applicants: you must fill in all grey sections of this report. This includes the section below, your full name and date of birth at the end of each page and the declaration on page 8.

Important: This report is only valid for 4 months from date of examination.

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Email add	iress	_		_				_				

Medical professionals must fill in all green sections on this report.

D4

Important information for doctors carrying out examinations.

Before you fill in this report, you must check the applicant's identity and decide if you are able to fill in the Vision assessment on page 2. If you are unable to do this, you must inform the applicant that they will need to ask an optician or optometrist to fill in the Vision assessment.

Examining medical professional

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Important: Signatures must be provided at the end of this report

1

Lice	ver & Vehicle ensing ency	Medical examin Vision ass To be filled in by a	sessm	ne	nt	doctor	D4
t S	the applicant's visual a Snellen Snellen expr	e scale you are using to ex	press	5.	Does the applicant any of the following ability to drive?	report symptoms of	Yes No
i	is at least 6/7.5 in one in the other. (a) Please provide und for each eye. Snell or minus (-) are no	e eye and at least 6/60 corrected visual acuities len readings with a plus (+ t acceptable. If 6/7.5, 6/60)		 (a) Intolerance to g rather than disc (b) Impaired contra (c) Impaired twiligh 	ity	
((b) Are corrective lens			,	Does the applicant ophthalmic conditio visual acuity or visu If Yes, please give f	on affecting their	Yes No
	If Yes, please prov the correction wor with a plus (+) or n If 6/7.5, 6/60 stand	ide the visual acuities usin n for driving. Snellen readi ninus (-) are not acceptabl dard is not met, the applica assessment by an optician	ings e. ant	7.	Details or additiona	l information	
((c) What kind of corre to meet this stand Glasses Cont		ther				
		reater than plus (+)8 idian of either lens? In for driving,	es No L es No L es No	unde	rtaking vision asses	tor, optician or optom ssment	
t	ls there a history of ar that may affect the ap field of vision (central If Yes, please give full	plicant's binocular and/or peripheral)?	es No t	exam aker	nination and the ap n into consideratio	pplicant's history ha	s been
			F		of signature e provide your GO	C or GMC number	ММҮҮ
[DVLA will commission		[Docto	or, optometrist or o	ptician's stamp	
(F S	Patch or Gla	and give full details in Q7 sses Other n/without (if other plea	se				
Appl	licant's full name	Please d	o not det	ach	n this page	ate of birth DD	ММҮҮ

Driver & Vehicle
Licensing
Agency

Medical examination report **Medical assessment**

Must be filled in by a doctor

1 Neurological disorders

1	Neurological disorders		2	Diabetes mellitus	
s th diso f N f Ye	ase tick ✓ the appropriate boxes ere a history or evidence of any neurological rder (see conditions in questions 1 to 11 below)? o, go to section 2, Diabetes mellitus es, please answer all questions below and enclose rele pital notes.	No Devant	If No If Ye	es the applicant have diabetes mellitus? o, go to section 3, Cardiac es, please answer all questions below. Is the diabetes managed by:	Yes
1.	Yes Has the applicant had any form of seizure?		2.	 (a) Insulin? If No, go to 1c If Yes, please give date started on insulin. (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 (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? (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 	7. Ye:
2.	you must supply medical reports. Has the applicant experienced Yes dissociative/'non-epileptic' seizures? (a) If Yes, please give 200 000 000 000 000 date of most recent episode. (b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	No		 (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.	Stroke or TIA? Yes If Yes, give date. If Yes, give date. (a) Has there been a full recovery? If Yes, was the carotid artery stenosis (b) Has a carotid ultrasound been undertaken? If Yes, was the carotid artery stenosis >50% in either carotid artery? If Yes, was the carotid artery?	No		 a hypoglyaemic episode? (b) If Yes, is there full awareness of hypoglycaemia? Is there a history of hypoglycaemia in the last 12 months requiring the 	Yes
4. 5.	(d) Is there a history of multiple strokes/TIAs? Sudden and disabling dizziness or vertigo within the last year with a liability to recur? Subarachnoid haemorrhage (non-traumatic)?			assistance of another person? If Yes, please give details and dates below.	
6. 7. 8.	Significant head injury within the last 10 years? Any form of brain tumour? Other intracranial pathology?		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. 	Yes
9. 10. 11.	Chronic neurological disorder(s)?		6.	Has there been laser treatment or intra-vitreal treatment for retinopathy?	Ye
Ар	plicant's full name			Date of birth D D M M	

Yes No

3 Cardiac	c Peripheral arterial disease (excluding Buerger's disease)
a Coronary artery disease	aortic aneurysm/dissection
Is there a history or evidence of Yes No coronary artery disease? If No, go to section 3b, Cardiac arrhythmia If Yes, please answer all questions below and enclose relevant hospital notes.	Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? If No, go to section 3d, Valvular/congenital heart disease 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 If Yes If Yes	1. Peripheral arterial disease? Yes No (excluding Buerger's disease)
of the last known attack. Image: Constraint of the last known attack. 2. Acute coronary syndrome including myocardial infarction? Yes If Yes, please give date. Image: Constraint of the last known attack.	Yes No 2. Does the applicant have claudication?
3. Coronary angioplasty (PCI)? Yes No If Yes, please give date of most recent intervention.	3. Aortic aneurysm? Yes No If Yes: If Site of aneurysm: Thoracic
4. Coronary artery bypass graft surgery? Yes No If Yes, please give date. If Yes, please give date.	Abdominal (b) Has it been repaired successfully? (c) Please provide latest transverse aortic
5. If Yes to any of the above, are there any Yes No 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.	diameter measurement and date obtained using measurement and date boxes.
	 Dissection of the aorta repaired successfully? Yes No If Yes, please provide copies of all reports including those dealing with any surgical treatment.
b Cardiac arrhythmia	5. Is there a history of Marfan's disease?YesNoIf Yes, please provide relevant hospital notes.
Is there a history or evidence of Yes No cardiac arrhythmia?	d Valvular/congenital heart disease
If Yes, please answer all questions below and enclose relevant hospital notes.1. Has there been a significant disturbance	Is there a history or evidence of Yes No valvular or congenital heart disease? If No, go to section 3e, Cardiac other If Yes, answer all questions below and provide
of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, Yes No atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?	relevant hospital notes. 1. Is there a history of congenital heart disease?
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?YesNo	2. Is there a history of heart value disease? Yes No
3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?	3. Is there a history of aortic stenosis?YesNoIf Yes, please provide relevant reports (including echocardiogram).
4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes No	4. Is there history of embolic stroke? Yes No
If Yes: (a) Please give date of implantation. (b) Is the applicant free of the symptome that	5. Does the applicant currently have significant symptoms? Yes No
 (b) Is the applicant free of the symptoms that caused the device to be fitted? (c) Does the applicant attend a pacemaker clinic regularly? 	6. Has there been any progression (either clinically or on scans etc) since the last licence application?
Applicant's full name	Date of birth D M Y Y

e Cardiac other

Is there a history or evidence of heart failure? Yes No If No, go to section 3f, Cardiac channelopathies I If Yes, please answer all questions and enclose	2. Has a (or pla
relevant hospital notes. 1. Please provide the NYHA class, if known.	3. Has a (or pla
 2. Established cardiomyopathy? Yes No If Yes, please give details in section 9, page 7. 	(a) If fra
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No	4. Has a (or pla
4. A heart or heart/lung transplant?	5. Has a (or pla
5. Untreated atrial myxoma? Yes No	6. Has a (or pla
f Cardiac channelopathies	(or pr
Is there a history or evidence of the Yes No following conditions?	7. Has a echo (or pla
Yes No 1. Brugada syndrome?	4 Psy
2. Long QT syndrome?YesNoIf Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.	Is there a illness wit If No, go If Yes, ple
g Blood pressure	1. Signif
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.	2. Psych past 1
1. Please record today's best resting blood pressure reading. /	3. (a) De (b) Ar in
2. Is the applicant on anti-hypertensive treatment? Yes No If Yes, please provide three previous readings with dates if available.	pc 5 Sul
	Is there a
	or depend If No, go If Yes, ple
	1. Is the in the
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).	(a) Is (b) Ha de
h Cardiac investigations	If Yes,
Have any cardiac investigations beenYesNoundertaken or planned?Image: Complexity of the second	2. Persis (a) Is
If No, go to section 4, Psychiatric illness	3. Use of pre
1. Is there a history of the following:Yes No(a) left bundle branch block (LBBB)?Image: Comparison of the following:	(a) If
(b) right bundle branch block (RBBB)?	(b) Is (c) Ha
If yes to (a) or (b), please provide relevant report(s) or comment in section 9, page 7.	tre If Yes,
Applicant's full name	

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)?	Yes	No
3.	Has an echocardiogram been undertaken (or planned)?	Yes	No
	(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?		
4.	Has a coronary angiogram been undertaken (or planned)?	Yes	No
5.	Has a 24 hour ECG tape been undertaken (or planned)?	Yes	No
6.	Has a loop recorder been implanted (or planned)?	Yes	No
7.	Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?	Yes	No
4	Psychiatric illness		
illn If I	there a history or evidence of psychiatric ess within the last 3 years? No, go to section 5, Substance misuse /es, please answer all questions below.	Yes	No
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?(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?	Yes	No
5	Substance misuse		
or If I	there a history of drug/alcohol misuse dependence? No, go to section 6, Sleep disorders ⁄es, please answer all questions below.	Yes	No
1.	 Is there a history of alcohol dependence in the past 6 years? (a) Is it controlled? (b) Has the applicant undergone an alcohol detoxification programme? If Yes, give date started: 	Yes	No
2.	Persistent alcohol misuse in the past 3 years? (a) Is it controlled?	Yes	No
3.	 Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? (a) If Yes, the type of substance misused? (b) Is it controlled? (c) Has the applicant undertaken an opiate treatment programme? 	Yes	No
	If Yes, give date started	1 Y	

6	Sleep disorders	6	Does the applicant have a histor of liver disease of any origin?	ory Yes
1.	Sleep Apnoea Syndrome or any other medical	Yes No	If Yes, is this the result of alcohol misuse?	
	condition causing excessive sleepiness?		If Yes, please give details in se	ction 9, page 7.
	If No, go to section 7, Other medical condition			N/s s
	If Yes, please give diagnosis and answer all que below.	estions 7	. Is there a history of renal failure	
			If Yes, please give details in see page 7.	ction 9,
			page 7.	
		8		
	 a) If Obstructive Sleep Apnoea Syndrome, pleandicate the severity: 	ase	respiratory disease causing ch	ronic hypoxia?
	Mild (AHI <15)			takon causo Yes
	Moderate (AHI 15 - 29)	9	 Does any medication currently the applicant side effects that of 	laken cause
	Severe (AHI >29)		safe driving?	
	Not known		If Yes, please fill in section 8, M	ledication
	If another measurement other than AHI is us	sed, it	and give symptoms in section	9, page 7.
	must be one that is recognised in clinical pr		0. Does the applicant have any o	ther medical Yes
	as equivalent to AHI. DVLA does not prescr different measurements as this is a clinical i	edi	condition that could affect safe	
	Please give details in section 9 page 7, Further		If Yes, please provide details in s	section 9, page 7.
	b) Please answer questions (i) to (vi) for all slee	ер		
	conditions.	8	Medication	
		res No Pla	ease provide details of all current	medication including
	(ii) Is it controlled successfully?	ey	e drops (continue on a separate s	sheet if necessary).
	(iii) If Yes, please state treatment.		Medication	Dosage
			medication	Decage
		íes No R	leason for taking:	
	(iv) Is applicant compliant with treatment?			DDMMV
	(v) Please state period of control:		pproximate date started (if known)	
	vears months			
	years months		Medication	Dosage
	(vi) Date of last review.			
		R	leason for taking:	
7	Other medical conditions	A	pproximate date started (if known)	DDMMY
1.	Is there a history or evidence of narcolepsy?	Yes No	Medication	Dosage
2.	Is there currently any functional impairment	res No B	leason for taking:	
	that is likely to affect control of the vehicle?			
0			pproximate date started (if known)	
3.	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant	res No		
	liability to metastasise cerebrally?		Medication	Dosage
4.	is there any inness that may cause significant	res No R	eason for taking:	
	fatigue or cachexia that affects safe driving?		opproximate date started (if known)	
	X	res No		
5.	Is the applicant profoundly deaf?			
	If Yes, is the applicant able to communicate		Medication	Dosage
	in the event of an emergency by speech	res No		
	or by using a device, e.g. a textphone?		leason for taking:	
		A	pproximate date started (if known)	DDMMY

No Yes

No

No

No

No

Date of birth

Applicant's full name

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

	of specialists or consulta
Consultant in	
Reason for attendance	
Name	
Address	
Date of last appointment:	DDMMY
Consultant in	
Reason for attendance	
Name	
Address	
Date of last appointment:	DDMMY
If more consultants seen give d	letails on a separate she
Please make sure all sections of t	he form have been filled i
Please make sure all sections of t The form will be returned to you it I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a c registered within the EU, if the r	the form have been filled i f you do not do this. ad in by me at examination history into account. I als C registered and license doctor who is medically
Please make sure all sections of t The form will be returned to you it I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a registered within the EU, if the r the UK.	the form have been filled in f you do not do this. The d in by me at examination history into account. I also registered and license doctor who is medically report was filled in outsi
Please make sure all sections of t The form will be returned to you it I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a c registered within the EU, if the r the UK.	the form have been filled if f you do not do this. ed in by me at examination history into account. I all C registered and license doctor who is medically report was filled in outsing r
Please make sure all sections of t The form will be returned to you if I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a d registered within the EU, if the r the UK. Signature of examining docto	the form have been filled if f you do not do this. ed in by me at examination history into account. I all C registered and license doctor who is medically report was filled in outsing r
Please make sure all sections of t The form will be returned to you if I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a d registered within the EU, if the r the UK. Signature of examining docto	the form have been filled in f you do not do this. ed in by me at examination history into account. I all C registered and license doctor who is medically report was filled in outsi r
Please make sure all sections of t The form will be returned to you if I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a d registered within the EU, if the r the UK. Signature of examining docto	the form have been filled if f you do not do this. ed in by me at examination history into account. I all C registered and license doctor who is medically report was filled in outsing r
Please make sure all sections of t The form will be returned to you if I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a d registered within the EU, if the r the UK. Signature of examining docto	the form have been filled in f you do not do this. The d in by me at examination history into account. I als C registered and license doctor who is medically report was filled in outsid
Please make sure all sections of t The form will be returned to you it I confirm that this report was fille and I have taken the applicant's confirm that I am currently GMC to practise in the UK or I am a registered within the EU, if the r the UK.	the form have been filled in f you do not do this. ed in by me at examination history into account. I also C registered and license doctor who is medically report was filled in outsion r
and I have taken the applicant's confirm that I am currently GMO to practise in the UK or I am a o registered within the EU, if the r the UK. Signature of examining docto	the form have been filled in f you do not do this. ed in by me at examination history into account. I also C registered and license doctor who is medically report was filled in outsion r

The applicant must fill in this page

Applicant's declaration

You **must** fill in this section and **must not** alter it in any way.

Please read the following important information carefully then sign to confirm the statements below.

Important information about fitness to drive

As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.

These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.

Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory panel members.

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.

Name
Signature
Date
I authorise the Secretary of State to

I authorise the Secretary of State to correspond with medical professionals via electronic channels (fax and/or email)

Yes		No	L
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Checklist

• Have you signed and dated the declaration?

have been enclosed?

Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes

Yes

Important

This report is valid for 4 months from the date the doctor, optician or optometrist signs it.

Please return it together with your application form.

Applicant's consent and declaration

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.

Important information about Consent

I accept that as part of the investigation into my fitness to drive, Westmorland and Furness Council may require me to undergo further medical examination or some form of practical assessment. In these circumstances, those personnel involved will require my background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, specialist consultants, orthoptists at eye clinics or paramedical staff at a driving assessment centre.

Only information relevant to the assessment of my fitness to drive will be released. In addition, where the circumstances of my case appear exceptional, the relevant medical information may need to be further considered, where such further examination / consideration attracts a cost this will be met by me the applicant, (you will be advised of any further costs as appropriate to determine your application) and where matters of a medical nature exist the application may then be determined by the Council's Regulatory Sub-Committee. (The HC/PH Driver licensing process is managed to strict principles of confidentiality, where applications are to be determined by the Council's Regulatory Sub-Committee such meetings are held to the exclusion of the press and public).

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to Westmorland and Furness Council's medical adviser.

I authorise Westmorland and Furness Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to hold a HC/PH Drivers Licence, to doctors, paramedical, DVLA 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.

During the period of application and any period when holding a private hire/hackney carriage driver licence, I will immediately inform Westmorland and Furness Council, in writing, of any deterioration in health or of any injury or condition that would affect my ability to drive. (This is in addition to the requirement of Section 94 of the Road Traffic Act 1988 requiring any driver to notify the Secretary of State of any relevant disability.

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

Applicant Signature:	Date:	

