

**MEDICAL REPORT ON AN APPLICANT FOR A HACKNEY CARRIAGE OR
PRIVATE HIRE VEHICLE DRIVER'S LICENCE**

Sections 1-10 of this medical report must be carried out by the applicant's own general practitioner (GP) or another GP at the applicant's registered practice that has full access to their medical records.

The Vision assessment must be carried out by an optician, optometrist or doctor.

Notes to the Medical Practitioner

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act 1976 to provide a Medical Examination Report that a person is physically fit to drive a Hackney Carriage or Private Hire Vehicle.

Please note that the licensing authority requires all applicants to meet the DVLA Group II medical standard.

In completing this Medical Certificate, Medical Practitioners MUST have regard to the current edition of the booklet "*Assessing Fitness to Drive- a guide for medical professionals*" issued by the Drivers Medical Group, DVLA, Swansea. This can be viewed on-line at: <https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals>

Where appropriate please provide as much detail as possible with relevant questions. In addition where specific medical investigations have taken place (e.g. exercise cardiac testing, echocardiography, EEG) or where relevant specialist reports (e.g. outpatient or discharge reports) are available then copies of these should accompany the application form and details recorded in **Section 6**. Failure to do so may delay the application process.

- Please complete this form in full including **Section 10** – GP Declaration and whether the applicant meets or does not meet the Group 2 Medical requirements. The form must be signed and dated and include the Surgery stamp.
- Any fee charged is payable direct by the applicant to the GP
- When attending the appointment applicants must take photo identification a passport or DVLA driver licence with them so that the Doctor can confirm the identity of the person attending medical. GP's must ensure the identity of the individual who has attended for the Medical Assessment and must write the

full name and date of birth on the bottom of each sheet of the medical certificate.

- The applicant must complete Driver Declaration in front of the doctor who is carrying out the examination.

Applicant's Full Name:	
Applicant's Full Address:	
Post Code:	

Date of Birth:		National Insurance No:	
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Is the applicant registered with your surgery? Yes No

Have you had access to the Applicant's Medical Summary Records? Yes No

How long has the applicant been registered at this practice? [Click or tap to enter a date.](#)

Vision Assessment

To be completed by an Optician, Optometrist or Doctor

Please check the appropriate boxes

1	Is the visual acuity at least 6/7.5 in the better eye or at least 6/60 in the other (corrective lenses may be worn) as measured by the Snellen chart	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Do corrective lenses have to be worn to achieve this standard?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	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 <input type="checkbox"/> No <input type="checkbox"/>
4	If a correction is worn, is it well tolerated?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6	Is there any diplopia? Is it controlled?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Does the applicant have any other ophthalmic condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If **Yes** to 5, 6, or 7 please give details in **section 6** and enclose any relevant visual field charts or hospital letters.

Please state the visual acuity of each eye (see INF4D). Snellen readings with a (+) or (-) are not acceptable. If 6/7.5, 6/60, standard is not met. The applicant may need further assessment by an optician.

Uncorrected		Corrected	
R	L	R	L

Examining Doctor/Optician/Optomertist (Print) Name:

Signature:		Date:	
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GOC, HIPC or GMC No:									
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Section 1 – Neurological Diseases

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

If no go to **Section 2**. If yes answer all questions below; Give details in **Section 6** where you have answered 'Yes' and enclose relevant hospital notes.

1	Has the applicant had any form of seizure?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	a) Has the applicant had more than one attack?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	b) Date of first Attack: DD/MM/YYYY Date of last Attack: DD/MM/YYYY	
	c) Is the applicant currently on anti-epileptic medication? If 'Yes' please give details of current medication in Section 7	Yes <input type="checkbox"/> No <input type="checkbox"/>
	d) If no longer treated, please give date when the treatment ended	DD/MM/YYYY
	e) Has the applicant had a brain scan?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	f) Has the applicant had an EEG?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Stroke or TIA? If yes please give date:	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
	a) Has there been a full recovery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	b) Has the applicant had an EEG?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Sudden and disabling dizziness /vertigo within the past 1 year with liability recur	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Subarachnoid Haemorrhage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Serious traumatic brain injury within the last 10 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6	Any form of brain tumour?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Other brain surgery or abnormality?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Chronic Neurological Disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Parkinson's Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Is there any history of blackout or impaired consciousness within the past 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11	Does the applicant suffer from narcolepsy?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 2 – Diabetes Mellitus

Does the applicant have Diabetes Mellitus? (if no go to **Section 3**) Yes No

If **yes** please answer **all** of the following questions

1.	(a) Is the diabetes managed by insulin? If yes please give date started on insulin	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
	(b) If treated with insulin is there evidence of at least 3 continuous months of blood glucose readings stored on a memory meter(s)? If 'No please give details in Section 6 of the form	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(c) Are there other injectable treatments?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(d) Is there a Sulphonyl urea or a Glinide?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(e) Oral hypoglycaemic agents or diet?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(f) Diet Only?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes to any (a-e) fill in current medication in Section 7		
2.	Are you satisfied that the applicant has provided evidence (last 3 months) that-	
	(a) Blood sugar is tested at least twice every day?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(b) Blood sugar is tested at times relevant to *driving? (*no more than 2 hours before the start of a journey and every 2 hours whilst driving)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have confidence that the applicant:		
	(c) Keeps fast-acting carbohydrate within easy reach whilst driving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(d) Has a clear understanding of diabetes and the necessary precautions for safe driving	Yes <input type="checkbox"/> No <input type="checkbox"/>
3.	Is there any evidence of impaired awareness of hypoglycaemia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person	Yes <input type="checkbox"/> No <input type="checkbox"/>
5.	(a) Is there any evidence of loss of visual field?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, to 4-5 above please give details in Section 6 .		
6	Has there been any laser treatment or intravitreal treatment for retinopathy? If yes please give date(s) of treatment	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY DD/MM/YYYY DD/MM/YYYY

Section 3 – Cardiac

Section 3A - 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**

1	Has the applicant suffered from angina? If yes please give date of last known attack	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
2	Acute coronary syndrome, including myocardial infarction? If yes please give date	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
3	Coronary angioplasty (PCI)? If yes give date of most recent intervention	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
4	Coronary artery bypass graft surgery? If yes please give date	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY

Section 3B – Cardiac Arrhythmia

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

If No go to **section 3c**

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

1	Has there been a significant disturbance of cardiac rhythm (ie. sinoatrial disease, significant atrioventricular conduction defect, and atrial flutter/fibrillation, narrow or broad complex tachycardia) in the last 5 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Has the arrhythmia been controlled satisfactorily for at least 3 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Has a pacemaker been fitted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(a) If yes please give date	DD/MM/YYYY
	(b) Is the patient free of symptoms that caused the device to be fitted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(c) Does the patient attend a pacemaker clinic regularly?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 3C – Peripheral Arterial Disease

Is there a history or evidence of peripheral arterial disease? Yes No

(Excluding Buerger’s disease aortic aneurysm/dissection)

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

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

1	Peripheral Arterial Disease?(excluding Buerger’s disease)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Does the applicant have claudication? If Yes, how long in minutes can the applicant walk at a brisk pace before being symptom-limited:	Mins
3	Aortic aneurysm?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(a) Site of aneurysm?	Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/>
	(b) Has it been repaired successfully?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(c) Is the transverse diameter currently > 5.5cm If not please provide latest measurement and date obtained	Yes <input type="checkbox"/> No <input type="checkbox"/> Measurement DD/MM/YYYY
4	Dissection of the aorta repaired successfully? If Yes please provide copies of all reports to include those dealing with any surgical treatment	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Is there a history of Marfan’s disease? If Yes please provide relevant hospital notes	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 3D – Valvular / Congenital Heart Disease

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

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

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

1	Is there a history of congenital heart disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Is there a history of heart valve disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Is there a history of aortic stenosis? If Yes please provide relevant reports	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Is there a history of embolism (not pulmonary embolism)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Does the applicant currently have significant symptoms?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6	Has there been any progression since the last licence application? (where relevant)	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 3E – Cardiac Other

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

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

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

1	Established cardiomyopathy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Has a left ventricular assist device (LVAD) been implanted?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	A heart or heart/lung transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Untreated atrial myxoma?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 3F – Cardiac Channelopathies

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

If **No** go to **section 3g**

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

1	Brugada syndrome?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Long QT syndrome? If Yes to either, give details and enclose copies of relevant hospital notes	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 3G – Blood Pressure

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

1	Please record today's best resting blood pressure reading	Reading
2	Is the applicant on ant-hypertensive treatment? If Yes, please provide three previous readings with dates if available	Yes <input type="checkbox"/> No <input type="checkbox"/> Reading 1 DD/MM/YYYY Reading 2 DD/MM/YYYY Reading 3 DD/MM/YYYY
3	Is there a history of malignant hypertension? If Yes please provide details in Section 6 (including date of diagnosis and any treatment etc)	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 3F – Cardiac Investigations

Have any cardiac investigations been undertaken or planned?

Yes No

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

If **Yes** answer questions 1-6

1	Has a resting ECG been undertaken? If yes does it show:	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(a) pathological Q waves?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(b) left bundle branch block	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(c) right bundle branch block?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes to a, b, or c please provide a copy of the relevant ECG report or comment at Section 6		
2	Has an exercise ECG been undertaken? If yes please give date Provide details in Section 6 and relevant reports if available	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
3	Has an echocardiogram been undertaken or planned? (a) If yes please give date (b) Provide details in Section 6 and relevant reports if available (c) If undertaken, is/was the left ejection fraction greater than or equal to 40%? Provide relevant reports	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Has a coronary angiogram been undertaken? If yes please give date Provide details in Section 6 and relevant reports if available	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
5	Has a 24 hour ECG tape been undertaken? If yes please give date Provide details in Section 6 and relevant reports if available	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY
6	Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? If yes please give date Provide details in Section 6 and relevant reports if available	Yes <input type="checkbox"/> No <input type="checkbox"/> DD/MM/YYYY

Section 4 – Psychiatric Illness & Substance Misuse

Is there a history of psychiatric illness or drug/alcohol abuse within the last three years? Yes No

If **No** go to question 5. If **Yes** please answer all questions and provide full details in **Section 6**, Including dates, period of stability and, where appropriate, consumption and frequency of use.

1	Significant psychiatric disorder within the past 6 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2	Psychosis or hypomania/mania within the past 12 months, including psychotic depression?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Dementia or cognitive impairment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Persistent alcohol misuse in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Alcohol dependency in the past 3 years?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6	Persistent drug misuse in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Drug dependency in the past three years?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Section 5 – General

All of the following questions must be answered. If **Yes** to any, give full details in **Section 6**

And enclose copies of relevant hospital notes

1	Is there any history of, or evidence of obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes please give the diagnosis: Diagnosis details	
	a) If obstructive Sleep Apnoea Syndrome please indicate the severity? 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.	
	Mild (AHI<15) <input type="checkbox"/>	Moderate (AHI 15-19) <input type="checkbox"/>
	Severe (AHI > 29) <input type="checkbox"/>	Not known <input type="checkbox"/>
	(b) Please answer all questions (i) to (vi) for sleep conditions:	
	(i) Date of diagnosis	DD/MM/YYYY
	(ii) Is it controlled successfully?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(iii) If yes please state treatment	

	Treatment Details	
	(iv) Is the applicant compliant with treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(v) Please state period of control	Years Months
	(vi) Date of last review	DD/MM/YYYY
2	Is there currently any functional impairment that is likely to affect control of the vehicle?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	Is the applicant profoundly deaf? If yes, is the applicant able to communicate in the event of an emergency by speech or by using a device e.g. textphone?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6	Does the applicant have a history of liver disease of any origin? If yes please give details in Section 6	Yes <input type="checkbox"/> No <input type="checkbox"/>
7	Is there a history of renal failure? If yes please give details in Section 6	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9	Does any medication currently taken cause the applicant side effects that could affect safe driving? If yes please give details in Section 6	Yes <input type="checkbox"/> No <input type="checkbox"/>
10	Does the applicant have any other medical condition that could affect safe driving? If yes please give details in Section 6	Yes <input type="checkbox"/> No <input type="checkbox"/>

Additional Information

Applicant's Weight (Kg): Applicant's Height (cm):

Number of alcohol units consumed each week:

Does the applicant smoke? Yes No

Date of last appointment: DD/MM/YYYY

Section 6 – Further Details

Please provide further details and forward copies of relevant hospital notes. Please do not send any notes that do not relate to 'Fitness to Drive'

Section 7 – Medication

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

Medication	Dosage
Reason for taking:	
Date started: DD/MM/YYYY	

Medication	Dosage
Reason for taking:	
Date started: DD/MM/YYYY	

Medication	Dosage
Reason for taking:	
Date started: DD/MM/YYYY	

Medication	Dosage
Reason for taking:	
Date started: DD/MM/YYYY	

Section 8 – Declarations

This section must be completed and must not be altered in any way

On occasion, as part of the investigation into your fitness to drive a hackney carriage or private hire vehicle, The Licensing Authority may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your medical background details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre.

Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by the Licensing Authority. Such information would be subject to legal restrictions on confidentiality

Applicant's Consent & Declaration

This declaration must be completed by the applicant in front of the GP (Doctor) who is carrying out the medical examination and must not be altered in any way.

I understand that Carmarthenshire Council may in certain circumstances, as part of its assessment of my fitness to drive a hackney carriage or private hire vehicle, require additional information about my medical fitness.

I declare that I have checked the details I have given on this Group II Medical Assessment Application Form, and that to the best of my knowledge and belief they are correct.

I declare that I have told my doctor about any medical symptoms which may affect my driving.

I authorise my doctor(s) and specialist(s) to release reports/additional information to Carmarthenshire Council about my medical condition if necessary ie where an application/review needs to be determined at a hearing (relating to medical fitness to drive). I declare that I have checked the details I have given on the enclosed questionnaire and that to the best of my knowledge they are correct.

I authorise Carmarthenshire Council to release, where applicable, medical information to my doctor(s) and/or specialist(s) about the outcome of any hearing relating to my medical fitness to drive a hackney carriage or private hire vehicle.

I understand that Carmarthenshire Council will never under any circumstances release information that is not relevant to fitness to drive, nor would the Council expect to receive this from your doctor(s).

Full Name (Print):	
Signature:	Date:

Details:

Address:	
	Postcode:

Date of Birth	DD/MM/YYYY
Hone Number:	
Mobile Number:	
Email Address:	

General Practitioner (Doctor) Declaration

To be completed by the General Practitioner carrying out the examination

I CERTIFY THAT: I am the named applicant's General Practitioner / General practitioner with full access to the applicants NHS records at the time of the examination

<p>I CERTIFY THAT I have examined the above named person and that he/she Meets the group 2 standards of medical fitness, as applied by the DVLA to the licensing of lorry and bus drivers, which is required for licensed hackney carriage and private hire drivers.</p> <p>Signature of Doctor:</p> <p>Date:</p>	<p>I CERTIFY THAT I have examined the above named person and that he/she does Not Meet the group 2 standards of medical fitness, as applied by the DVLA to the licensing of lorry and bus drivers, which is required for licensed hackney carriage and private hire drivers.</p> <p>Signature of Doctor:</p> <p>Date:</p>
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I declare that the answers to all questions are true to the best of my knowledge and belief. I understand that it is an offence for the person completing this form to make a false statement or omit relevant details.

GP Full Name (Print):

Signature:

Date:

Surgery Address:

Post Code:

Email:

Surgery Stamp: