Calderdale Council

Certificate of fitness to drive A Hackney Carriage or Private Hire vehicle

*** PLEASE NOTE THIS MEDICAL NEEDS COMPLETING BY YOUR OWN GP (Your Medical will NOT be accepted if it does not meet this criteria) ***

When completing this medical report and certificate, please have regard to the DVLA's *"At a glance guide to the current medical standards of fitness to drive"* and the Medical Commission's accident prevention booklet *"Medical aspects of fitness to drive"*. The main purpose of the medical report is to ascertain that the client is fit to drive and any additional information should only be disclosed to advise on recommended length of fitness (eg, insulin dependent diabetic).

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

Any additional information not relevant to the below two instances are not to be disclosed.

The medical practitioner must determine from the completed medical whether the applicant is or is not fit to drive under Group 2 standards.

Applicant Name: _____

Date of Birth: _____

Being a registered Medical Practitioner who is competent in undertaking DVLA Group 2 medical examinations, I have today examined the above applicant. I have examined the applicant medically to the DVLA Group 2 medical standards for Vocation Drivers and I consider the above applicant *;

**Please tick relevant box*

☐ Meets the DVLA Group 2 medical standards for vocational drivers and is **FIT** to drive a Hackney Carriage or Private Hire vehicle to Group 2 standards.

☐ Does not meet the DVLA Group 2 medical standards for vocational drivers and is **UNFIT** to drive a Hackney Carriage or Private Hire vehicle to Group 2 standards.

I confirm that the above applicant is registered with this surgery and has been registered

since _____ ***(**date must be completed**)***

Signed: _____ Date: _____

Name: _____
(BLOCK CAPITALS)

Surgery Stamp:

Medical examination report

Vision assessment

D4

Driver & Vehicle Licensing Agency

To be filled in by a doctor or optician/optometrist.

You MUST read the guidance notes on page 1 and the INF4D leaflet before completing this report.

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

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

   Snellen Snellen expressed as a decimal

   LogMAR

2. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard) YES NO

3. Were corrective lenses worn to meet this standard? YES NO

   If Yes, glasses contact lenses both together

4. Please state the visual acuity of each eye.

   Please convert any 3 metre readings to the 6 metre equivalent.

	Uncorrected	Corrected (using the prescription worn for driving)

5. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?

6. If correction is worn for driving, is it well tolerated?
   If No, please give full details in the box provided

If you answer yes to any of the following give details in the box provided.

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)?

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

8. Is there diplopia?

   (a) Is it controlled?

   If yes, please give full details in the box provided

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision?

10. Does the applicant have any other ophthalmic condition?

Details/additional information

Date of eyesight examination if different to date of signature

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicant's full name

Date of birth

Please do not detach this page

Driver & Vehicle Licensing Agency

Medical examination report
Medical assessment

Must be filled in by a doctor

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant as well as taking the applicant's history.
- Please answer all questions, and read the notes in the INF4D leaflet (information and useful notes) to help you complete this form

D4

1 Nervous system

Questions 1-4 below MUST be answered.

Please tick ✓ the appropriate box(es) YES NO

1. Has the applicant had any form of seizure?
   If **NO**, please go to **question 2 below**
   (a) Has the applicant had more than one attack?
   (b) Please give date of first and last attack
   First attack
   Last attack
   (c) Is the applicant currently on anti-epileptic medication?
   If **YES**, please fill in current medication in **section 8**
   (d) If no longer treated, please give date when treatment ended
   (e) Has the applicant had a brain scan?
   If **YES**, please give details in **section 6**
   (f) Has the applicant had an EEG?
   If **YES** to any of above, please supply reports if available.
2. Is there a history of blackout or impaired consciousness within the last 5 years?
   If **YES**, please give date(s) and details in **section 6**
3. Does the applicant suffer from narcolepsy
   If **YES**, please give date(s) and details in **section 6**
4. Is there a history of, or evidence of **ANY** conditions listed at a-h?
   If **NO**, go to **section 2**
   If **YES**, please give full details in **section 6** and supply relevant reports
   (a) Stroke or TIA
   If **YES**, please give date
   Has there been a full recovery?
   Has a carotid ultra sound been undertaken?
   (b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur
   (c) Subarachnoid haemorrhage
   (d) Serious traumatic brain injury within the last 10 years
   (e) Any form of brain tumour
   (f) Other brain surgery or abnormality
   (g) Chronic neurological disorders
   (h) Parkinson's disease

2 Diabetes mellitus

YES NO

1. Does the applicant have diabetes mellitus?
   If **NO**, go to **section 3**
   If **YES**, please answer the following questions.
2. Is the diabetes managed by:-
   (a) Insulin?
   If **YES**, please give date started on insulin
   (b) If treated with insulin, are there at least 3 months of blood glucose readings stored on a memory meter(s)?
   If **NO**, please give details in **section 6**
   (c) Other injectable treatments?
   (d) A Sulphonylurea or a Glinide?
   (e) Oral hypoglycaemic agents and diet?
   If **YES** to any of a-e, please fill in current medication in **section 8**
   (f) Diet only?
3. (a) Does the applicant test blood glucose at least twice every day?
   (b) Does the applicant test at times relevant to 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?
4. Is there any evidence of impaired awareness of hypoglycaemia?
5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?
6. Is there evidence of:-
   (a) Loss of visual field?
   (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?
   If **YES** to any of 4-6 above, please give details in **section 6**
7. Has there been laser treatment or intra-vitreal treatment for retinopathy?
   If **YES**, please give date(s) of treatment.

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

3 Psychiatric illness

All questions must be answered

- Please enclose relevant hospital notes
- If applicant remains under specialist clinic(s), ensure details are given in **section 7.**

Is there a history of, or evidence of, ANY of the conditions listed at 1–7 below?

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

If yes to ANY of questions 4-7, please state how long this has been controlled

Please give details of past consumption or name of drug(s) and frequency

4 Cardiac

4a Coronary artery disease

	YES	NO
Is there a history of, or evidence of, coronary artery disease?		

If NO, go to section 4b

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

1. Has the applicant suffered from angina?
   If YES, please give the date of the last known attack
2. Acute coronary syndrome including myocardial infarction?
   If YES, please give date
3. Coronary angioplasty (P.C.I.)
   If YES, please give date of most recent intervention
4. Coronary artery by-pass graft surgery?
   If YES, please give date

4b Cardiac arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?		

If NO, go to section 4c

If YES, please answer all questions below and give details in section 6

1. Has there been a significant disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 5 years
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?
3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted?
4. Has a pacemaker been implanted?
   If YES:-
   (a) Please supply date of implantation
   (b) Is the applicant free of symptoms that caused the device to be fitted?
   (c) Does the applicant attend a pacemaker clinic regularly?

4c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/ dissection

	YES	NO
Is there a history of, or evidence of, ANY of the following:		

If NO, go to section 4d.
If YES, please answer all questions below and give details in section 6

	YES	NO
1. Peripheral arterial disease (excluding Buerger's disease)		
2. Does the applicant have claudication?		

If YES, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?

Please give details

3. Aortic aneurysm
   If YES:
   (a) Site of Aneurysm: Thoracic Abdominal
   (b) Has it been repaired successfully?
   (c) Is the transverse diameter currently > 5.5 cm?
   If NO, please provide latest measurement and date obtained
4. Dissection of the aorta repaired successfully
   If YES, please provide copies of all reports to include those dealing with any surgical treatment.
5. Is there a history of Marfan's disease?
   If YES, provide relevant hospital notes

Applicant's full name

Date of birth

4d Valvular/congenital heart disease

YES NO

Is there a history of, or evidence of, valvular/congenital heart disease?

If NO, go to section 4e

If YES, please answer all questions below and give details in section 6 of the form.

1. Is there a history of congenital heart disorder?
2. Is there a history of heart valve disease?
3. Is there a history of aortic stenosis?
   If YES, please provide relevant reports
4. Is there any history of embolism? (not pulmonary embolism)
5. Does the applicant currently have significant symptoms?
6. Has there been any progression since the last licence application? (if relevant)

4e Cardiac other

Does the applicant have a history of ANY of the following conditions: YES NO

If NO, go to section 4f

If YES, please answer ALL questions and give details in section 6

(a) a history of, or evidence of, heart failure?

(b) established cardiomyopathy?

(c) has a left ventricular assist device (LVAD) been implanted?

(d) a heart or heart/lung transplant?

(e) untreated atrial myxoma

4f Cardiac investigations

All questions must be answered YES NO

1. Has a resting ECG been undertaken?
   If YES, does it show:-
   (a) pathological Q waves?
   (b) left bundle branch block?
   (c) right bundle branch block?
   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 (or planned)?
   If YES, please give date and give details in section 6
   Please provide relevant reports if available

YES NO

3. Has an echocardiogram been undertaken (or planned)?
   (a) If YES, please give date and give details in section 6
   (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?
   Please provide relevant reports if available
4. Has a coronary angiogram been undertaken (or planned)?
   If YES, please give date and give details in section 6
   Please provide relevant reports if available
5. Has a 24 hour ECG tape been undertaken (or planned)?
   If YES, please give date and give details in section 6
   Please provide relevant reports if available
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?
   If YES, please give date and give details in section 6
   Please provide relevant reports if available

4g Blood pressure

1. Please record today's blood pressure reading

YES NO

2. Is the applicant on anti-hypertensive treatment?
   If YES provide three previous readings with dates if available

Applicant's full name

Date of birth

5 General

All questions must be answered

If YES to any, give full details in section 6 — YES NO

1. Is there currently any functional impairment that is likely to affect control of the vehicle?
2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?
3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?
4. 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. a textphone?
5. Does the applicant have a history of liver disease of any origin?
   If YES, please give details in section 6
6. Is there a history of renal failure?
   If YES, please give details in section 6
7. Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive day time sleepiness?
   If YES, please give diagnosis

   Please give
   (i) Date of diagnosis
   (ii) Is it controlled successfully?
   (iii) If YES, please state treatment
   (iv) Please state period of control
   (v) Date last seen by consultant
8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?
9. Does any medication currently taken cause the applicant side effects that could affect safe driving?
   If YES, please provide details of medication and symptoms in section 6
10. Does the applicant have an ophthalmic condition?
    If YES, please provide details in section 6
11. Does the applicant have any other medical condition that could affect safe driving?
    If YES, please provide details in section 6

6 Further details

Please forward copies of relevant hospital notes. PLEASE DO NOT send any notes not related to fitness to drive.

Applicant's full name

Date of birth

7 Consultants' details

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

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

8 Medication

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

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

9 Additional information

Patient's weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

Examining doctor's details

To be filled in by doctor carrying out the examination

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

10 Doctor's details (please print name and address in capital letters)

Name
Address

Telephone
Email address
Fax number

Surgery stamp

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

GMC registration number

Signature of medical practitioner

Date of examination D D M M Y Y

If you have filled in both the vision and medical assessments, both sections must be signed and dated.

Applicant's full name

Date of birth D D M M Y Y

Applicant's details

To be filled-in in the presence of the doctor carrying out the examination

D4

Please make sure that you have printed your name and date of birth on each page before sending this form with your application

11 Your details

Your full name

Your address

Email address

Date of birth

Home phone number

Work/daytime number

Date when first licensed to drive a lorry

and/or bus

About your doctor/group practice

Doctor/group name

Address

Phone

Email address

Fax number

12 Applicant's consent and declaration

Consent and declaration

This section **MUST** be filled in 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, DVLA may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical 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 one or more members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

Consent and declaration

I authorise my doctor(s) and specialist(s) to release reports/ medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and 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 **YES** **NO**

Inform my doctor(s) of the outcome of my case

Release reports to my doctor(s)

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