MEDICAL REPORT
Associated with an application for a
Hackney Carriage or Private Hire Drivers Licence

SECTION 57(2) LOCAL GOVERNMENT (MISCELLANEOUS PROVISIONS) ACT 1976

For the Applicant:

This medical report is the method by which Torridge District Council is advised that the applicant is medically fit to drive hackney carriage/private hire vehicles.

Applicants must be examined and certified as being medically fit (to a Group 2 Standard) by their registered GP or another GP in the practice with which they are registered, who must have taken into account previous medical history.

PLEASE NOTE: If you are unable to obtain an appointment with your registered practice then the Council may authorise the use of an alternative doctor. However the following conditions apply:

- **YOU MUST obtain the prior consent of Torridge District Council.**
- **YOU MUST obtain a summary of your medical history and current medication from your registered practice to take with you to the appointment.**

The Council may require a further examination or referral following this initial report.

You will be required to pay for your medical. The Council accepts no liability to pay for ANY costs associated with obtaining a medical report.

If this is your first application for a hackney carriage or private hire driver's licence, please note that further medical certificates will be required every five years. Drivers aged 65 and over must provide a medical certificate annually.

Vision Assessment

When booking your medical appointment check if your doctor can undertake a vision assessment.

If not, you will need to book an appointment with an optician and ensure they complete the vision assessment BEFORE you attend your medical appointment.

For the Applicant's Doctor:

This medical report and any supplementary information is for the confidential use of the Council.

Torridge District Council has adopted the Group 2 Medical Standards for Fitness to Drive Hackney Carriage and Private Hire Vehicles in accordance with the Driver and Vehicle Licensing Agency (DVLA) and Department for Transport Best Practice Guidance.

The Appendix D criteria for insulin treated diabetes is adopted in relation to hackney carriage and private hire drivers.

Group 2 Medical reports are only accepted from the applicant's own doctor, another doctor in the same practice, or an alternative doctor approved by the Council, taking into account an applicant's medical records.

In completing this certificate, GPs are asked to have regard to the document "Assessing Fitness to Drive" (current edition) published by the Department for Transport and available at www.gov.uk/dvla/fitnesstodrive

Vision Assessment

Only complete the vision assessment section if you are able to do so fully and accurately.

In order to undertake the vision assessment you must be able to confirm the strength of glasses (dioptres) from a prescription

You must be able to measure the applicant's visual acuity to at least 6/7.5 (decimal 0.8) of a Snellen chart.

We have advised the applicant that if they wear glasses to meet the required eyesight standard for driving they must bring their current prescription to the assessment.

If you are unable to undertake the vision assessment you must advise the applicant of this and the need for them to arrange for their optician or optometrist to complete the vision assessment section of the medical form.

Where applicants are required to go to an optician or optometrist, there is still a need for the applicant's doctor to undertake the final sign off of the medical certificate and indicate whether based on the information the driver concerned is fit or unfit to drive a hackney carriage/private hire vehicle.

MEDICAL EXAMINATION REPORT

VISION ASSESSMENT

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

You MUST read the guidance notes on page 2 before completing this report.

Applicant's full name	
Applicant's date of birth	

	VISION ASSESSMENT	YES	NO
1	Please confirm the scale you are using to express the driver's visual acuities. Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐		
2	a. Please provide uncorrected visual acuities for each eye RIGHT: LEFT:		
	b. Are corrective lenses worn for driving? **If NO go to question 3.** If **YES**, please provide the visual acuities using the correction worn for driving. RIGHT: LEFT:	☐	☐
	c. What kind of corrective lenses are worn to meet this standard? glasses ☐ contact lenses ☐ both together ☐		
	d. If glasses (not contact lenses) 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)? If **YES** please give details and dates in Q7	☐	☐
4	Is there diplopia? (a) If **YES**, is it controlled? If **YES**, please give details and dates in Q7	☐ ☐	☐ ☐

5	Does the applicant on questioning, report symptoms of any of the following that impairs their ability to drive? 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? If **YES**, please give details and dates in Q7 below	☐	☐
7	Details/additional information for previous questions		

You must sign and date this Section	
Name of examining doctor/optician (print)	
Signature of examining doctor/optician	
Date of signature	
Please provide your GOC or GMC number	
Doctor/optometrist/optician's stamp	

MEDICAL EXAMINATION REPORT

MEDICAL ASSESSMENT

To be filled in by a doctor that has access to the applicant's medical records and history.

Applicant's full name	
Applicant's date of birth	

Please tick the appropriate box(es)

	SECTION 1	YES	NO
1	**NEUROLOGICAL DISORDERS** Is there a history of, or evidence of any neurological disorder? If **YES**, please provide full details in Section 2.	☐	☐
2	**DIABETES MELLITUS** Does the applicant have diabetes mellitus? If **YES**, please provide full details in Section 2.	☐	☐
3A	**CARDIAC: CORONARY ARTERY DISEASE** Is there a history of, or evidence of, coronary artery disease? If **YES**, please provide full details in Section 2.	☐	☐
3B	**CARDIAC ARRHYTHMIA** Is there a history of, or evidence of, coronary artery disease? If **YES**, please provide full details in Section 2.	☐	☐
3C	**PERIPHERAL ARTERIAL DISEASE (excluding Buerger's disease), AORTIC ANEURYSM / DISSECTION** Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm / dissection? If **YES**, please provide full details in Section 2.	☐	☐
3D	**VALVULAR / CONGENITAL HEART DISEASE** Is there a history of, or evidence of, valvular/congenital heart disease? If **YES**, please provide full details in Section 2.	☐	☐
3E	**CARDIAC OTHER** Is there a history of, or evidence of heart failure? If **YES**, please provide full details in Section 2.	☐	☐
3F	**CARDIAC CHANNELOPATHIES** Is there a history of, or evidence of either of the following conditions: Brugada syndrome or Long QT syndrome? If **YES**, please provide full details in Section 2.	☐	☐
3G	**BLOOD PRESSURE** If resting blood pressure is 180mm/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 Section 2.	☐	☐
3H	**CARDIAC INVESTIGATIONS** Have any cardiac investigations been undertaken or planned? If **YES**, please provide full details in Section 2.	☐	☐

	SECTION 1 (continued)	YES	NO
4	**PSYCHIATRIC ILLNESS** Is there a history of, or evidence of, psychiatric illness within the last 3 years? If **YES**, please provide full details in Section 2.	☐	☐
5	**SUBSTANCE MISUSE** Is there a history of drug/alcohol misuse or dependence? If **YES**, please provide full details in Section 2.	☐	☐
6	**SLEEP DISORDERS** Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? If **YES**, please provide full details in Section 2.	☐	☐
7	**OTHER MEDICAL CONDITIONS**		
7A	Is there currently any functional impairment which is likely to affect control of the vehicle?	☐	☐
7B	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	☐	☐
7C	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	☐	☐
7D	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?	☐	☐
7E	Does the applicant have a history of liver disease of any origin? If **YES**, please give details in Section 10	☐	☐
7F	Is there a history of renal failure? If **YES**, please give details in Section 10	☐	☐
7G	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
7H	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 10	☐	☐
7I	Does the applicant have any other medical condition that could affect safe driving? If **YES**, please give details in Section 10	☐	☐
7J	Does the applicant have a medical condition, which is aggravated by exposure to dogs and is severe enough to require the Authority to issue an exemption from the requirement to carry guide dogs in taxi/private hire vehicles?	☐	☐

SECTION 2: FURTHER DETAILS

Please provide any further details from other sections. Please continue on separate sheet if required.

SECTION 3: EXAMINING DOCTOR'S SIGNATURE AND STAMP

To be completed by the doctor carrying out the examination.

Please ensure all Sections of the form have been completed. The form will be returned to you if you don't do this.

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

I have examined the applicant named below and having seen and paid full regard to his/her medical history and the criteria for a Group 2 vocational driver's licence as set out in the latest edition of the DVLA publication 'for Medical Practitioners – at a Glance Guide for Current Medical Standards of Fitness to Drive'.

I certify that the applicant: (√ as appropriate):

☐ **Meets the Group 2 standard and is fit to drive a hackney carriage/private hire vehicle.**

☐ **Does NOT meet the Group 2 standard and is unfit to drive a hackney carriage/private hire vehicle.**

Name of examining doctor:
Address:
Telephone:
Email address:
Surgery stamp:
Signature of examining doctor:
Date of signature:
Have you reviewed the applicant's medical records? **YES** ☐ **NO** ☐ If reviewing a print out of the medical records, please give the date of the printout:

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

SECTION 4: APPLICANTS DETAILS AND 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 Torridge District Council may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness to drive.

Declaration
I authorise my doctor and specialist to release reports and information about my condition which is relevant to my fitness to drive, to Torridge District Council.

I understand that Torridge District Council may disclose relevant medical information that is necessary to investigate my fitness to drive, to doctors and paramedical staff.

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.

Name:	
Address:	
Daytime Telephone:	
Mobile:	
Email:	
Signature:	
Date of signature:	

If this medical report has been completed by a doctor who is NOT your registered GP please provide the following information:

Registered GP's name:	
Registered GP's practice name and address:	

Please ensure all pages of this report have been completed.

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

Privacy Notice

Torridge District Council collects stores and processes your personal information in accordance with the requirements of the General Data Protection Regulation (Regulation (EU) 2016/679) and Data Protection Act 2018.

Our lawful basis has been determined as:
Public Task – in relation to personal data
Substantial Public Interest – in relation to 'special category' personal data

Personal information provided on this form may be shared with other council services where this assists in the delivery of those services.

Personal information provided on this form may be shared with third parties where we are legally obliged to do so, or where this is necessary to enable us to provide the service requested.

To view our full privacy policy including information on your rights, how to contact the Data Protection Officer, data retention information, more detail on information sharing and how to provide feedback or make a complaint, please see the privacy pages of our website
Website: http://www.torridge.gov.uk/privacypolicy/

Alternatively, a full copy of our privacy policy can be viewed at our main office or a copy can be requested by writing to the Data Protection Officer at Riverbank House, Bideford, Devon, EX39 2QG.