



## Medical Report: guidance notes

### Medical in confidence

Information required for Hackney Carriage and Private Hire Drivers under section 57 of Local Government (Miscellaneous Provisions) Act 1976.

### Note to the Doctor

The Council requires the Group 2 medical standards which apply to large goods vehicles and public carriage vehicles to apply in respect of hackney carriage and private hire driver licences. You may find it helpful to consult the DVLA's "At a glance Guide to the current Medical Standards of Fitness to Drive" available at [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/736938/assessing-fitness-to-drive-a-guide-for-medical-professionals.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736938/assessing-fitness-to-drive-a-guide-for-medical-professionals.pdf) **If any amendments or mistakes are made, please ensure you sign and date next to the amendment.**

### What the doctor has to do

1. Ensure the applicant completes the Applicants declaration.
2. Complete sections 1-10

### Notes for an applicant for a licence to drive Hackney Carriage (HC) or Private Hire Vehicle (PH)

- If this is your first application for a Hackney Carriage/Private Hire vehicle licence you must produce the Medical Examination form **completed by a doctor who is Registered General Practitioner at the practice you are registered at**. You must also do this if you are applying to renew your licence every 3 years thereafter until the age of 65.
- From the age of 65 a medical examination is required annually and this form must accompany each renewal.
- If you have any questions, please email [licensing@surreyheath.gov.uk](mailto:licensing@surreyheath.gov.uk)

### What you (the applicant) must do

1. Before you consult your doctor please read the notes "Medical standards for the drivers of Hackney Carriages or Private Hire vehicles for common medical conditions" found in the next page. If you have any of these conditions you will not meet the Council's medical standard and your application may be refused. However, each application will be considered on its own merit.
2. If after reading these notes, you have any doubts about your ability to meet the medical standards consult your doctor before you arrange for this medical form to be completed. The doctor may charge you for completing it. In the event of your application being refused, the fee you pay the doctor is not refundable. The Council has no responsibility for the fee payable to the doctor.
3. Complete the applicant's declaration of this report in the presence of the doctor carrying out the examination.
4. The Council must receive the report within 4 months of the doctor signing the report.
5. Please check that all sections have been completed fully. If any medical conditions are identified, please ensure an explanation is given in section 6.



## Medical standards for drivers of Hackney Carriage or Private Hire Vehicles for common medical conditions

1. It is the duty of you as the licence holder to inform us if you have a condition or are undergoing treatment or have a medical condition that may now, or in the future, affect your safety as a driver. You must inform us in writing and supply supporting medical reports/letters within 7 days of the start of the condition.
2. The standards are higher for Hackney Carriage and Private Hire drivers than those required for normal car drivers. This page is a list of common conditions that would bar someone from becoming a Hackney Carriage and or a Private Hire driver, it is not an exclusive list. If you are in any doubt as to whether your condition would affect your application please email the Licensing team at [licensing@surreyheath.gov.uk](mailto:licensing@surreyheath.gov.uk) for further advice.
3. The following conditions are a bar to holding a Hackney Carriage and or Private Hire driver licence:

### 3.1. Epileptic attack

Applicants must have been free of epileptic seizures for at least the last 10 years and have not taken anti-epileptic medication during this 10 year period. If these conditions cannot be met the Council may refuse or revoke the licence.

### 3.2. Diabetes

Insulin treated diabetics may not obtain a licence unless they held a Hackney Carriage and or Private Hire driver licence valid at 1 April 1991 and the Council had knowledge of the insulin treatment before 1 January 1991, or if they meet a strict criteria for diabetic control. If you believe you may meet these criteria please contact Licensing to discuss this further.

### 3.3. Eyesight

- a) Applicants for Hackney Carriage and Private Hire vehicle driver licences must have
  - i) A visual acuity of at least 6/7.5 (0.8 decimal) in the better eye; **and**
  - ii) A visual acuity of at least 6/60 (0.1 decimal) in the other eye; **and**
  - iii) Where glasses are worn to meet the minimum standards, they should have corrective power not exceeding +8 dioptres in any meridian of either lens.
- b) It is also necessary for all drivers of Group 2 vehicles to be able to meet the prescribed and relevant Group 1 visual acuity requirements:-
  - i) Must be able to meet the above prescribed standard for reading a number plate. In addition, the visual acuity (with the aid of glasses or contact lenses if worn) must be at least 6/12 (Snellen decimal 0.5) with both eyes open, or in the only eye if monocular.
- c) Applicants are barred from holding a Hackney Carriage and or Private Hire vehicle driver licence if they have
  - i) Uncontrolled diplopia (double vision)
  - ii) Or do not have a normal binocular field of vision

## 4. Other medical conditions

In addition to those medical conditions shown above, applicants (or licence holders) should be shown as unfit to drive a Hackney Carriage and or Private Hire vehicle if they are unable to meet the DVLA Group 2 guidelines in the following cases:

- 4.1. Within 3 months of myocardial infraction, any episode of unstable angina, CABG or coronary angioplasty
- 4.2. A significant disturbance of cardiac rhythm unless special criteria are met
- 4.3. Suffering from or receiving medication for angina or heart failure
- 4.4. Hypertension where the BP is consistently 180 systolic or over or 100 diastolic or over
- 4.5. A stroke, or TIA within the last 12 months
- 4.6. Unexplained loss of consciousness within the past 5 years



- 4.7. Meniere's and other conditions causing disabling vertigo, within the past year and with a liability to recurrence
- 4.8. Recent severe head injury with serious continuing after effects, or major brain surgery
- 4.9. Parkinson's disease, multiple sclerosis or other "chronic" neurological disorders likely to affect limb power and coordination
- 4.10. Suffering from a psychotic illness in the past 3 years, or suffering from dementia
- 4.11. Persistent alcohol, drug or substance misuse in the past 12 months or alcohol, drug or substance misuse in the past 3 years
- 4.12. Insuperable difficulty in communicating by telephone in an emergency
- 4.13. Any other serious medical conditions which may cause problems for road safety
- 4.14. If major psychotropic or neuroleptic medication is being taken
- 4.15. Any malignant condition within the last 2 years likely to metastasise to the brain for example malignant melanoma

A Hackney Carriage or Private Hire driver licence issued after cardiac assessment – usually for ischaemic or untreated heart valve disease – will usually be short-term and licence renewal will require satisfactory medical reports including an exercise or other functional test, as required from the DVLA. See Appendix C at:

<https://www.gov.uk/guidance/appendices-assessing-fitness-to-drive#appendix-c-cardiovascular-considerations>

# Medical examination report for a Taxi or Private Hire licence (group 2)



**This form must be completed by the applicant's GP or medical practice with access to the applicant's full medical history.**

An additional report may be needed from an optician/optometrist.

Guidance on the required standards for driving for both applicants and medical professionals is available via [www.gov.uk](http://www.gov.uk).

Medical professionals can refer to 'Assessing fitness to drive: a guide for medical professionals'.

Applicants can refer to 'Health conditions and driving'.

**All black outlined boxes must be answered. Pages 1 and 8 must be completed by the applicant.**

## Your details

Your name \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Date of birth \_\_\_\_\_

Daytime telephone number \_\_\_\_\_

email \_\_\_\_\_

## Your Doctor's details

Name of doctor \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email (if known) \_\_\_\_\_

**You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.**

# Medical examination report

## Vision assessment



To be filled in by a doctor or optician/optometrist

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. Please state the visual acuity of each eye (see INF4D).

Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

Uncorrected		Corrected (using prescription worn for driving)	
R	L	R	L

3. 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**

4. Were corrective lenses worn to meet this standard? **Yes**  **No**

If **Yes**, glasses  Contact lenses  Both together

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? **Yes**  **No**

6. If correction is worn for driving, is it well tolerated? **Yes**  **No**   
 If **No**, please give full 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)? **Yes**  **No**

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

8. Is there diplopia? **Yes**  **No**   
 (a) if **Yes**, 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 that impairs their ability to drive? **Yes**  **No**

10. Does the applicant have any other ophthalmic condition? **Yes**  **No**   
 If **Yes** to any of questions 7-10, please give full details in the box provided

### Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature

D	D	M	M	Y	Y
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Please provide your GOC, HPC or GMC number

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Doctor/optometrist/optician's stamp

Applicant's full name

Date of birth

D	D	M	M	Y	Y
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Please do not detach this page

# 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.

1 Neurological disorders		Yes	No
Please tick ✓ the appropriate box(es)			
Is there a history of, or evidence of any neurological disorder?			
If No, go to section 2		<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please answer all the questions below, give details in section 6, page 6 and enclose relevant hospital notes.			
		Yes	No
1.	Has the applicant had any form of seizure?	<input type="checkbox"/>	<input type="checkbox"/>
(a)	Has the applicant had more than one attack?	<input type="checkbox"/>	<input type="checkbox"/>
(b)	Please give date of first and last attack		
	First attack	<input type="text" value="DD"/>	<input type="text" value="MM"/>
	Last Attack	<input type="text" value="DD"/>	<input type="text" value="MM"/>
(c)	Is the applicant currently on anti-epileptic medication?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please fill in current medication in section 8, page 7			
(d)	If no longer treated, please give date when treatment ended	<input type="text" value="DD"/>	<input type="text" value="MM"/>
(e)	Has the applicant had a brain scan?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please give details in section 6, page 6			
(f)	Has the applicant had an EEG?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, to any of above, please supply reports if available.			
2.	Stroke or TIA?	Yes	No
If Yes, please give date		<input type="text" value="DD"/>	<input type="text" value="MM"/>
Has there been a FULL recovery?		<input type="checkbox"/>	<input type="checkbox"/>
Has a carotid ultrasound been under taken?		<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was the carotid artery stenosis >50% in either carotid artery?		<input type="checkbox"/>	<input type="checkbox"/>
3.	Sudden and disabling dizziness/vertigo within the last year with a liability to recur?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Subarachnoid haemorrhage?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Serious traumatic brain injury within the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Any form of brain tumour?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Other brain surgery or abnormality?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Chronic neurological disorders?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Is there a history of blackout or impaired consciousness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Does the applicant suffer from narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>

2 Diabetes mellitus		Yes	No
Does the applicant have diabetes mellitus?			
If No, go to section 3, page 4		<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please answer all the questions below.			
1.	Is the diabetes managed by:	Yes	No
(a)	Insulin?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please give date started on insulin			
		<input type="text" value="DD"/>	<input type="text" value="MM"/>
(b)	If treated with insulin, are there at least 3 continuous months of blood glucose readings stored on a memory meter(s)?	<input type="checkbox"/>	<input type="checkbox"/>
If No, please give details in section 6, page 6			
(c)	Other injectable treatments?	<input type="checkbox"/>	<input type="checkbox"/>
(d)	A Sulphonylurea or a Glinide?	<input type="checkbox"/>	<input type="checkbox"/>
(e)	Oral hypoglycaemic agents and diet?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes to any of (a)-(e), please fill in Current medication in section 8, page 7			
(f)	Diet only?	<input type="checkbox"/>	<input type="checkbox"/>
2.	(a) Does the applicant test blood glucose at least twice every day?	Yes	No
(b)	Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every	<input type="checkbox"/>	<input type="checkbox"/>
(c)	Does the applicant keep fast acting carbohydrate within easy reach when driving?	<input type="checkbox"/>	<input type="checkbox"/>
(d)	Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Is there any evidence of impaired awareness of hypoglycaemia?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>
4.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	Yes	No
	If Yes, please give dates and details in section 6	<input type="checkbox"/>	<input type="checkbox"/>
5.	Is there evidence of:	Yes	No
(a)	Loss of visual field?	<input type="checkbox"/>	<input type="checkbox"/>
(b)	Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes to any of 4-5 above, please give details in section 6, page 6			
6.	Has there been laser treatment or intra-vitreous treatment for retinopathy?	Yes	No
		<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please give date(s) of treatment.			
<input type="text"/>			

Applicant's full name

Date of birth

**3 Cardiac**

**a 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 of the form and enclose relevant hospital notes.

1. Has the applicant suffered from Angina?  Yes  No

If Yes, please give the date of the last known attack  DD  MM  YY

2. A acute coronary syndrome including myocardial infarction?  Yes  No

If Yes, please give date  DD  MM  YY

3. Coronary angioplasty (PCI)?  Yes  No

If Yes, please give date of most recent intervention  DD  MM  YY

4. Coronary artery bypass graft surgery?  Yes  No

If Yes, please give date  DD  MM  YY

5. If Yes to any of the above, are there any physical health problems (e.g. mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?  Yes  No

**b Cardiac arrhythmia**

Is there a history of, or evidence of, Cardiac arrhythmia?  Yes  No

If No, go to section 3c

If Yes, please answer all questions below and give details in section 6, page 6 and enclose relevant hospital notes.

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?  Yes  No

2. Has the arrhythmia been controlled satisfactorily for at least 3 months?  Yes  No

3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted?  Yes  No

4. Has a pacemaker been implanted?  Yes  No

If Yes: (a) Please give date of implantation  DD  MM  YY

(b) Is the applicant free of the symptoms that caused the device to be fitted?  Yes  No

(c) Does the applicant attend a pacemaker clinic regularly?  Yes  No

**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?  Yes  No

If No, go to section 3d

If Yes, please answer all questions below and give details in section 6 page 6, and enclose relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease)  Yes  No

2. Does the applicant have claudication? If Yes, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?  Yes  No

Please give details

3. Aortic aneurysm?  Yes  No

If Yes: (a) Site of aneurysm: Thoracic  Abdominal

(b) Has it been repaired successfully?  Yes  No

(c) Is the transverse diameter currently >5.5 cm?  Yes  No

If No, please provide latest measurement and date obtained

DD  MM  YY

4. Dissection of the aorta repaired successfully?  Yes  No

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?  Yes  No

If Yes, please provide relevant hospital notes

**d Valvular/congenital heart disease**

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

If No, go to section 3e

If Yes, please answer all questions below and give details in section 6 page 6, and enclose relevant hospital notes.

1. Is there a history of congenital heart disease?  Yes  No

2. Is there a history of heart valve disease?  Yes  No

3. Is there a history of aortic stenosis? If Yes, please provide relevant reports  Yes  No

4. Is there any history of embolism? (not pulmonary embolism)  Yes  No

5. Does the applicant currently have significant symptoms?  Yes  No

6. Has there been any progression since the last license application? (if relevant)  Yes  No

Applicant's full name

Date of birth  DD  MM  YY

**e Cardiac other**

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

1. Established cardiomyopathy? Yes  No

2. Has a left ventricular assist device (LVAD) been implanted? Yes  No

3. A heart or heart/lung transplant? Yes  No

4. Untreated atrial myxoma? Yes  No

**f Cardiac channelopathies**

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

1. Brugada syndrome? Yes  No

2. Long QT syndrome? Yes  No   
 If **Yes** to either, please give details in section 6 and enclose relevant hospital notes.

**g Blood pressure**

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

1. Please record today's **best resting** blood pressure reading

2. Is the applicant on anti-hypertensive treatment? Yes  No   
 If **Yes**, please provide three previous readings with dates if available

	D	D	M	M	Y	Y
	D	D	M	M	Y	Y
	D	D	M	M	Y	Y

3. Is there a history of malignant hypertension? Yes  No   
 If **Yes**, please provide details in section 6 (including date of diagnosis and any treatment etc)

**h Cardiac investigations**

Have any cardiac investigations been undertaken or planned? Yes  No   
 If **No**, go to **section 4**  
 If **Yes**, please answer questions 1-6

1. Has a resting ECG been undertaken? Yes  No   
 If **Yes**, does it show:  
 (a) pathological Q waves?    
 (b) left bundle branch block?    
 (c) right bundle branch block?

If **Yes** to a, b, c please provide a copy of the relevant ECG report or comment at **section 6, page 6**.

2. Has an exercise ECG been undertaken (or planned)? Yes  No   
 If **Yes**, please give date and give details in **section 6, page 6**  
 Please provide relevant reports if available

D D M M Y Y

3. Has an echocardiogram been undertaken (or planned)? Yes  No   
 (a) If **Yes**, please give date and give details in **section 6, page 6**  
 (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?    
 Please provide relevant reports if available

D D M M Y Y

4. Has a coronary angiogram been undertaken (or planned)? Yes  No   
 If **Yes**, please give date and give details in **section 6, page 6**  
 Please provide relevant reports if available

D D M M Y Y

5. Has a 24 hour ECG tape been undertaken (or planned)? Yes  No   
 If **Yes**, please give date and give details in **section 6, page 6**  
 Please provide relevant reports if available

D D M M Y Y

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? Yes  No   
 If **Yes**, please give date and give details in **section 6, page 6**  
 Please provide relevant reports if available

D D M M Y Y

**4 Psychiatric illness**

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

1. Significant psychiatric disorder within the past 6 months? Yes  No

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes  No

3. Dementia or cognitive impairment? Yes  No

4. Persistent alcohol misuse in the past 12 months? Yes  No

5. Alcohol dependence in the past 3 years? Yes  No

6. Persistent drug misuse in the past 12 months? Yes  No

7. Drug dependence in the past 3 years Yes  No

If 'Yes' to any questions above, please provide full Details in section 6, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

Applicant's full name

Date of birth D D M M Y Y

5

General

All questions must be answered. If Yes to any, give full details in section 6 and enclose relevant hospital notes.

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

If Yes, please give diagnosis

[Text box for diagnosis]

- (a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity

- Mild (AHI,15)
Moderate (AHI 15 – 29)
Severe (AHI>29)
Not known

If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. SHBC does not prescribe different measurements as this is a clinical issue. Please give details in section 6.

- (b) Please answer questions ( i )-( vi ) for all sleep conditions

- (i) Date of diagnosis [DD][MM][YY] Yes No

- (ii) Is it controlled successfully? Yes No

- (iii) If Yes, please state treatment

[Text box for treatment]

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

- (v) Please state period of control

[Text box for period of control]

- (vi) Date of last review [DD][MM][YY]

6

Further details

Please forward copies of relevant hospital notes. Please do not send any notes not related to fitness to drive.

[Large empty box for hospital notes]

Applicant's full name

[Text box for full name]

Date of birth

[DD][MM][YY]

- 2. Is there currently any functional impairment that is likely to affect control of the vehicle? Yes No
3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? Yes No
4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? Yes No
5. Is the applicant profoundly deaf? If Yes, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone? Yes No
6. Does the applicant have a history of liver disease of any origin? If Yes, please give details in section 6 Yes No
7. Is there a history of renal failure? If Yes, please give details in section 6 Yes No
8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes No
9. Does any medication currently taken cause the applicant side effects that could affect safe driving? If Yes, please provide details of medication and symptoms in section 6 Yes No
10. Does the applicant have any other medical condition that could affect safe driving? If Yes, please provide details in section 6 Yes No

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
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Consultant in
Name
Address

Date of last appointment 

D	D	M	M	Y	Y
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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:	

Applicant's full name

Date of birth

D	D	M	M	Y	Y
---	---	---	---	---	---

9

**Additional information**

Patient's weight (kg)

Height (cms)

Details of smoking habits, if any

Number of alcohol units taken each week

10

**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 your 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.

Doctors Name

Signature of practitioner

GMC Registration Number

Date of signature 

D	D	M	M	Y	Y
---	---	---	---	---	---

Doctor's stamp

# The applicant must complete 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 statement below.

### Important information about fitness to drive

As part of the investigation into your fitness to drive, we (Surrey Heath Borough Council) may require your medical records to be referred to a suitably qualified medical advisor. If we do, the people involved will need your background medical details to carry out an appropriate assessment. We will only release information relevant to the assessment of your fitness to drive. In addition, where you are medically assessed as not meeting Group 2 but you want to have your application referred to a licensing sub-committee for determination, your medical information will need to be the members. The licensing committee membership conforms to the principle of confidentiality.

### Declaration

I authorise my doctor(s) and specialist(s) to release reports/medical a information about my medical conditions relevant to my fitness to drive, to Surrey Heath Borough Council's adviser.

I authorise Surrey Heath Borough Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, opticians/optometrists, members of Surrey Heath Borough Council's Licensing Committee.

I declare that I have checked the details I have given on the form and that, to the best of my knowledge and belief, they are correct.

I understand that it is a criminal offence if I make false declaration to obtain a licence can lead to prosecution.

<b>Name</b>	_____
<b>Signature</b>	_____
<b>Date</b>	_____

I authorise Surrey Heath Borough Council to:

Inform my doctors about the outcome of my case

Yes

No

Release reports to my doctors

### Checklist

- Have you signed and dated the declaration?
- Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?

**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.**