

MEDICAL DECLARATION FORM

THIS FORM MUST BE COMPLETED AND SUBMITTED WITH THE
D4 DVLA GROUP 2 MEDICAL EXAMINATION REPORT



Applicant Details (To be completed by the Applicant)

Name:	Surname		Date of Birth	DD / MM / YYYY
	First/Middle			
Address:				
		Postcode		
Tel. No.	Home		Mobile	
Email:				
GP/Practice Name (where currently registered)				
GP/Practice Address				
		Postcode		
GP/Practice Tel. No.				

Medical Practitioner Details (To be completed by the Doctor carrying out the examination)

Name		Surgery Stamp	
Address			
			Postcode:
Tel. No.			
Email			

In my judgement the applicant is **FIT/UNFIT** (*delete as applicable*) to act as a driver of a Hackney Carriage and/or Private Hire Vehicle in accordance with the DVLA Group 2 Medical Standard

Signature of Medical Practitioner

Date