

**MEDICAL EXAMINATION REPORT**  
**FOR A PRIVATE HIRE/HACKNEY CARRIAGE DRIVER LICENCE IN ACCORDANCE**  
**WITH DVLA MEDICAL STANDARD FOR LGV AND PCV GROUP 2 ENTITLEMENT**  
**Section 57 of the Local Government (Miscellaneous Provisions) Act 1976**

**TO THE MEDICAL PRACTITIONER**

**THIS REPORT MUST BE COMPLETED IN FULL BY THE DRIVER/APPLICANT'S OWN GP, OR A MEDICAL PRACTITIONER WHO HAS FULL ACCESS TO THE APPLICANT'S MEDICAL RECORDS/HISTORY NOT A SUMMARY. YOU MAYBE ASKED TO PROVIDE EVIDENCE OF THIS.**

Stockton-on-Tees Borough Council require all licensed drivers/applicants to meet Group 2 Entitlement, as set out in the DVLA publication [www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals](http://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals)

Only complete the Vision Assessment if you can fully and accurately complete **ALL** the questions. If you are unable to do this, you must tell the driver/applicant that they will need to arrange to have this part of the assessment completed by an optician or optometrist and you should not confirm that driver/applicant meets the Group 2 standards without a completed vision assessment.

**PLEASE ANSWER ALL QUESTIONS AND ONCE COMPLETED, PLEASE SIGN THE CERTIFICATE OF FITNESS ON PAGE 14.**

By declaring the driver/applicant is fit to drive **YOU** are declaring the driver/applicant meets the DVLA Group 2 Medical Standards. This is applied because of the amount of time the driver spends at the wheel and the increased risk to passengers and other members of the public if the driver/ applicant were not fit to this standard.

**TO THE DRIVER/APPLICANT**

**THIS REPORT MUST BE COMPLETED IN FULL BY THE DRIVER/APPLICANT'S OWN GP, OR A MEDICAL PRACTITIONER WHO HAS FULL ACCESS TO THE APPLICANT'S MEDICAL RECORDS/HISTORY NOT A SUMMARY. YOU MAYBE ASKED TO PROVIDE EVIDENCE OF THIS.**

**PLEASE CHECK THAT ALL SECTIONS OF THE REPORT HAS BEEN FULLY COMPLETED BY THE GP/MEDICAL PRACTITIONER BEFORE LEAVING THE SURGERY AND THAT YOU HAVE COMPLETED THE APPLICANT'S CONSENT AND DECLARATION ON PAGE 13.**

The Medical Examination Report must be submitted to the Licensing Service **no more than 28 days** from the date of signature. A report submitted after this period will be considered invalid.

Upon reaching the age of 45, a Medical Report is required every 5 years until the age of 65 and then annually. The Licensing Authority accepts no liability to pay it.

**TO BOTH DRIVER/APPLICANT AND MEDICAL PRACTITIONER**

On 22 December 2014 a bin lorry collided with pedestrians in the city centre of Glasgow, Scotland, killing six people and injuring fifteen others. The driver of the council-owned vehicle said he had passed out at the wheel. A similar blackout had happened to him in the driving seat of a bus. A fatal accident inquiry ruled that the crash might have been avoided if the driver had told the truth about his medical history. His licence was revoked indefinitely on medical grounds.

## GUIDANCE NOTES – MEDICAL STANDARDS FOR DRIVERS OF PASSENGER CARRYING VEHICLES

Medical standards for drivers of passenger carrying vehicles are higher than those required for Group 1 (car and motorcycle drivers).

**Eyesight** – Applicants must have, as measured by the 6 metre Snellen chart;

- A visual acuity of at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye.
- A visual acuity of at least 6/60 (decimal Snellen equivalent 0.1) in the worse eye. This may be achieved with or without glasses or contact lenses.
- If glasses are worn, the distance spectacle prescription of either lens used must not be of a corrective power greater than plus 8 (+8) dioptries.

**Visual Field** – The horizontal visual field should be at least 160 degrees; the extension should be at least 70 degrees left and right and 30 degrees up and down. No defects should be present within a radius of the central 30m degrees.

**Monocular Vision** – Drivers who have sight in one eye only or their sight in one eye has deteriorated to less than 0.05 (3/60) cannot normally be licensed to drive Group 2 vehicles.

**Uncontrolled Symptoms of Double Vision** – If you have uncontrolled symptoms of double vision, or you have double vision treated with a patch, you will not be allowed to hold a Group 2 licence.

**Epilepsy or Liability to Epileptic Attacks** – If you have been diagnosed as having epilepsy, (this includes all events; major, minor and auras), you will need to remain free of seizures with taking anti-epilepsy medication for 10 years. If you have a condition that causes an increased liability to seizures, for example a serious head injury, the risk of you having a seizure must have fallen to no greater than 2% per annum prior to application.

**Isolated Seizure** – If you have had only an isolated seizure, you may be entitled to drive from the date of the seizure, provided that you are able to satisfy the following criteria;

- No relevant structural abnormality has been found in the brain on imaging.
- No definite epileptic activity has been found on EEG (record of brain waves).
- You have not been prescribed medication to treat the seizure for at least 5 years since the seizure.
- You have the support of your neurologist.
- Your risk of a further seizure is considered to be 2% or less per annum (each year).

**Insulin Treated Diabetes** – If you have insulin treated diabetes you may be eligible to apply for a Group 2 licence. An annual assessment by a hospital consultant specialising in the treatment of diabetes is required and you will have to meet strict criteria for controlling and monitoring your diabetes. This includes having at least 3 months of blood glucose readings available for inspection on a blood glucose meter with a memory function.

**Other Medical Conditions** – An applicant is likely to be refused a Group 2 licence if they cannot meet the recommended medical guidelines for any of the following;

- With 3 months of a coronary artery bypass graft (CABG).
- Angina, heart failure or cardiac arrhythmia which remains uncontrolled.
- Implanted cardiac defibrillator.
- Hypertension where the blood pressure is persistently 180 systolic or more and/or 100 diastolic or more.
- A stroke or transient ischemic attack (TIA) within the last 12 months.
- Unexplained loss of consciousness with liability to recurrence.
- Meniere's disease, or any other sudden and disabling vertigo within the past year, with a liability to recurrence.
- Major brain surgery and/or recent severe head injury with serious continuing after-effects or a likelihood of causing seizures.
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders with symptoms likely to affect safe driving.
- Psychotic illness in the past 3 years.
- Serious psychiatric illness.
- If major psychotropic or neuroleptic medication is being taken.
- Alcohol and/or drug misuse in the past 1 year of alcohol and/or drug dependence in the past 3 years.
- Dementia.
- Cognitive impairment likely to affect safe driving.
- Cancer of the lung.
- Any malignant condition in the last 2 years, with a significant liability to metastasise (spread) to the brain.
- Any other serious medical condition likely to affect the safe driving of a Group 2 vehicle.

# VISION ASSESSMENT

TO BE COMPLETED BY AN OPTICIAN, OPTOMETRIST OR DOCTOR

Applicant's full name		Date of birth	D	D	M	M	Y	Y
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1. Please confirm the scale you are using to express the applicant's visual acuities  
**(PLEASE ✓ TICK AS APPROPRIATE)**

Snellen  Snellen expressed as a decimal  LogMAR

2. The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other.

(a) Please provide uncorrected visual acuities for each eye. Snellen readings with 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

Right  Left

(b) Are corrective lenses used for driving? Yes  No   
**IF NO, GO TO Q3**

**IF YES, PLEASE PROVIDE THE VISUAL ACUITIES USING THE CORRECTION WORN FOR DRIVING. SNELLEN READINGS WITH PLUS (+) OR MINUS (-) ARE NOT ACCEPTABLE. IF 6/7.5, 6/60 STANDARD IS NOT MET, APPLICANT MAY NEED FURTHER ASSESSMENT BY AN OPTICIAN**

Right  Left

(c) What kind of corrective lenses are used to meet this standard?

Glasses  Contact lenses  Both together

(d) If glasses are worn for driving is the corrective power greater than plus (+)8 dioptres in any meridian or either lens? Yes  No

(e) If correction is worn for driving, is it well tolerated? Yes  No   
**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)? Yes  No

**IF YES, PLEASE GIVE FULL DETAILS BELOW**

4. Is there diplopia? Yes  No

(a) Is it controlled? Yes  No

**PLEASE INDICATE BELOW AND GIVE FULL DETAILS IN Q7**

Patch or glasses with frosted glass  Glasses with/without prism  Other (if other, please provide details)

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**

(a) Intolerance to glare (causing incapacity rather than discomfort) and/or Yes  No

(b) Impaired contrast sensitivity and/or

Yes  No

(c) Impaired twilight vision

Yes  No

6. Does the applicant have any other ophthalmic condition?  
**IF YES, PLEASE GIVE FULL DETAILS IN Q7**

Yes  No

7. Details or additional information

EXAMINING DOCTOR/OPTICIAN'S DETAILS						
Name of examining doctor or optician undertaking vision assessment						
Company or practice address						
Company or practice telephone number and email address						
GOC or GMC registration number						
Signature of examining doctor or optician						
Date of examination	D	D	M	M	Y	Y
Doctor/optometrist/optician's stamp						

# MEDICAL EXAMINATION REPORT

## FOR A PRIVATE HIRE/HACKNEY CARRIAGE DRIVER LICENCE IN ACCORDANCE WITH DVLA MEDICAL STANDARD FOR LGV AND PCV GROUP 2 ENTITLEMENT

### NOTE FOR APPLICANTS

To be completed by your own doctor or a doctor who has access to your **FULL** medical records/history not a summary prior to the completion, who is competent in undertaking DVLA Group 2 medical examinations and is familiar with the current requirements of Group 2 Medical Standards applied by the DVLA in the current version of the publication [www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals](http://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals)

**1 – NEUROLOGICAL DISORDERS**  
**PLEASE TICK ✓ THE APPROPRIATE BOXES.**

Is there a history or evidence of any neurological disorder (see questions 1 to 11 below)? Yes  No

**IF NO, PLEASE GO TO 2 – DIABETES MELLITUS**

**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW AND ENCLOSE RELEVANT HOSPITAL NOTES**

1. Has the applicant had any form of seizure? Yes  No

(a) Has the applicant had more than one seizure episode? Yes  No

(b) **IF YES, PLEASE GIVE DATE OF FIRST AND LAST EPISODE** First episode 

D	D	M	M	Y	Y
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Last episode 

D	D	M	M	Y	Y
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(c) Is the applicant currently on anti-epileptic medication? Yes  No   
**IF YES, PLEASE FILL IN 8 – MEDICATION**

(d) If no longer treated, when did treatment end? 

D	D	M	M	Y	Y
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(e) Has the applicant had a brain scan? Yes  No   
**IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS**

(f) Has the applicant had an EEG? Yes  No

**IF YES TO ANY OF THE ABOVE, YOU MUST SUPPLY MEDICAL REPORTS**

2. Has the applicant experienced dissociative/'non-epileptic' seizures? Yes  No

(a) **IF YES, PLEASE GIVE DATE OF MOST RECENT EPISODE**

D	D	M	M	Y	Y
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(b) **IF YES, HAVE ANY OF THESE EPISODE(S) OCCURRED OR ARE LIKELY TO OCCUR WHILST DRIVING?** Yes  No

3. Stroke or TIA? Yes  No

**IF YES, PLEASE GIVE DATE**

D	D	M	M	Y	Y
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(a) Has there been a **FULL** recovery? Yes  No

(b) Has a carotid ultrasound been undertaken? Yes  No

(c) If Yes, was the carotid artery stenosis >50% in either carotid artery? Yes  No

(d) Is there a history of multiple strokes/TIAs? Yes  No

4. Sudden and disabling dizziness/vertigo with the last year with a liability to recur? Yes  No
5. Subarachnoid haemorrhage (non-traumatic)? Yes  No
6. Significant head injury within the last 10 years? Yes  No
7. Any form of brain tumour? Yes  No
8. Other intracranial pathology? Yes  No
9. Chronic neurological disorder(s)? Yes  No
10. Parkinson's disease? Yes  No
11. Blackout, impaired consciousness or loss of awareness within the last 10 years? Yes  No

## 2 – DIABETES MELLITUS

Does the applicant have diabetes mellitus? Yes  No

**IF NO, PLEASE GO TO 3 – CARDIAC**

**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW**

1. Is the diabetes managed by
- (a) Insulin? Yes  No

**IF NO, GO TO 1C**

**IF YES, PLEASE GIVE DATE STARTED ON INSULIN**

D	D	M	M	Y	Y
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- (b) Are there a least 3 months of blood glucose readings stored on a memory meter or meters? Yes  No

**IF NO, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS**

- (c) Other injectable treatments? Yes  No

- (d) A Sulphonyl urea or a Glinide? Yes  No

- (e) Oral hypoglycaemic agents and diet? Yes  No

**IF YES TO ANY OF (A) TO (E), PLEASE FILL IN THE MEDICATION IN 8 – MEDICATION**

- (f) Diet only? Yes  No

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 2 hours while driving)? Yes  No

- (c) Does the applicant keep fast-acting carbohydrate within easy reach when driving? Yes  No

- (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? Yes  No

3. (a) Has the applicant ever had a hypoglycaemic episode? Yes  No
- IF YES, IS THERE FULL AWARENESS OF HYPOGLYCAEMIA?** Yes  No
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 BELOW**

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5. Is there evidence of;
- (a) Loss of visual field? Yes  No
- (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? Yes  No
- IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS**
6. Has there been laser treatment or intra-vitreous treatment for retinopathy? Yes  No
- IF YES, PLEASE GIVE MOST RECENT DATE OF TREATMENT**
- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| D | D | M | M | Y | Y |
|---|---|---|---|---|---|

<b>3 – CARDIAC</b>
<b>3A – CORONARY ARTERY DISEASE</b>

Is there a history or evidence of coronary artery disease? Yes  No

**IF NO, PLEASE GO TO 3B – CARDIAC ARRHYTHMIA**

**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW AND ENCLOSE RELEVANT HOSPITAL NOTES**

1. Has the applicant suffered from angina? Yes  No
- IF YES, PLEASE GIVE THE DATE OF LAST KNOWN ATTACK**
- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
2. Acute coronary syndromes including myocardial infarction? Yes  No
- IF YES, PLEASE GIVE DATE**
- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
3. Coronary angioplasty (PCI)? Yes  No
- If Yes, please give date of most recent intervention
- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
4. Coronary artery bypass graft surgery? Yes  No
- IF YES, PLEASE GIVE DATE**
- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| D | D | M | M | Y | Y |
|---|---|---|---|---|---|

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

**PLEASE GIVE DETAILS BELOW**

**3B – CARDIAC ARRHYTHMIA**

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

**IF NO, PLEASE GO TO 3C – PERIPHERAL ARTERIAL DISEASE**

**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW AND ENCLOSE RELEVANT HOSPITAL NOTES**

1. Has there been a significant disturbance or cardiac rhythm (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or 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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes  No
4. Has a pacemaker or biventricular pacemaker/cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes  No

**IF YES, PLEASE COMPLETE BELOW**

(a) Please give date of implantation 

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

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

**3C – PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER’S DISEASE) AORTIC ANEURYSM/DISSECTION**

Is there a history or evidence of peripheral arterial disease (excluding Buerger’s disease) aortic aneurysm/dissection? Yes  No

**IF NO, PLEASE GO TO 3D – VALVULAR/CONGENITAL HEART DISEASE**

**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW AND ENCLOSE RELEVANT HOSPITAL NOTES**

1. Peripheral arterial disease (excluding Buerger’s disease) Yes  No
2. Does the applicant have claudication? Yes  No

If Yes, would the applicant be able unable to undertake 9 minutes of the standard Bruce Protocol ETT? Yes  No

3. Aortic aneurysm Yes  No

**IF YES, PLEASE COMPLETE (a) (b) (C)**

(a) Site of Aneurysm Thoracic  Abdominal

(b) Has it been repaired successfully? Yes  No

(c) Please provide latest transverse aortic diameter measurement and date obtained  .  cm 

D	D	M	M	Y	Y
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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**

**3D – VALVULAR/CONGENITAL HEART DISEASE**

- Is there a history or evidence of valvular/congenital heart disease? Yes  No   
**IF NO, PLEASE GO TO 3E – CARDIAC OTHER**  
**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW 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 (including echocardiogram) Yes  No
4. Is there history of embolic stroke? Yes  No
5. Does the applicant currently have significant symptoms? Yes  No
6. Has there been any progression (either clinically or on scans etc since the last licence application, if relevant)? Yes  No

**3E – CARDIAC OTHER**

- Is there a history or evidence of heart failure? Yes  No   
**IF NO, PLEASE GO TO 3F – CARDIAC CHANNELOPATHIES**  
**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW AND ENCLOSE RELEVANT HOSPITAL NOTES**
1. Please provide the NYHA class, if known.
2. Established cardiomyopathy? Yes  No   
**IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS**
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes  No
4. A heart or heart/lung transplant? Yes  No
5. Untreated atrial myxoma? Yes  No

**3F – CARDIAC CHANNELOPATHIES**

- Is there a history or evidence of the following conditions? Yes  No   
**IF NO, PLEASE GO TO 3G – BLOOD PRESSURE**
1. Brugada syndrome? Yes  No
2. Long QT syndrome? Yes  No

**IF YES TO EITHER, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS AND ENCLOSE RELEVANT HOSPITAL NOTES**

### 3G – BLOOD PRESSURE

#### **ALL QUESTIONS MUST BE ANSWERED**

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 the box provided

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

	/	
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2. Is the applicant on anti-hypertensive treatment?

Yes

No

**IF YES, PROVIDE THREE PREVIOUS READINGS WITH DATES, IF AVAILABLE**

	/	
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D	D	M	M	Y	Y
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	/	
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D	D	M	M	Y	Y
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D	D	M	M	Y	Y
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3. Is there a history of malignant hypertension?

Yes

No

**IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS (INCLUDING DATE OF DIAGNOSIS AND ANY TREATMENT ETC)**

### 3H – CARDIAC INVESTIGATIONS

Have any cardiac investigations been under taken or planned?

Yes

No

**IF NO, PLEASE GO TO 4 – PSYCHIATRIC ILLNESS**

**IF YES, PLEASE ANSWER QUESTIONS 1 TO 7**

1. Has a resting ECG been undertaken?

Yes

No

**IF YES, DOES IT SHOW;**

(a) pathological Q waves?

Yes

No

(b) left bundle branch block?

Yes

No

(c) right bundle branch block?

Yes

No

**IF YES TO (a), (b) OR (c) PLEASE PROVIDE A COPY OF THE RELEVANT ECG REPORT OR COMMENT IN 9 – FURTHER DETAILS**

**NOTE: IF YES TO QUESTIONS 2 TO 6 PLEASE GIVE DATES IN THE BOXES PROVIDED, GIVE DETAILS IN 9 – FURTHER DETAILS AND PROVIDE RELEVANT REPORTS**

2. Has an exercise ECG been undertaken (or planned)?

Yes

No

Date undertaken/planned

D	D	M	M	Y	Y
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3. Has an echocardiogram been undertaken (or planned)?

Yes

No

Date undertaken/planned

D	D	M	M	Y	Y
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(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?

Yes

No

4. Has a coronary angiogram been undertaken (or planned)? Yes  No
- Date undertaken/planned 

D	D	M	M	Y	Y
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5. Has a 24 hour ECG tape been undertaken (or planned)? Yes  No
- Date undertaken/planned 

D	D	M	M	Y	Y
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6. Has a loop recorder been implanted (or planned)? Yes  No
- Date undertaken/planned 

D	D	M	M	Y	Y
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7. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Yes  No
- Date undertaken/planned 

D	D	M	M	Y	Y
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#### 4 – PSYCHIATRIC ILLNESS

Is there a history or evidence of psychiatric illness within the last 3 years? Yes  No

**IF NO, PLEASE GO TO 5 – SUBSTANCE MISUSE**  
**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW**

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

**IF YES, PLEASE CONFIRM CONDITION BELOW**

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

3. (a) Dementia or cognitive impairment? Yes  No

(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses? Yes  No

#### SECTION 5 – SUBSTANCE MISUSE

Is there a history of drug/alcohol misuse or dependence? Yes  No

**IF NO, PLEASE GO TO 6 – SLEEP DISORDERS**  
**IF YES, PLEASE ANSWER ALL QUESTIONS BELOW**

1. Is there a history of alcohol dependence in the last 6 years? Yes  No

(a) Is it controlled? Yes  No

(b) Has the applicant undergone an alcohol detoxification programme? Yes  No

If Yes, give date started. 

D	D	M	M	Y	Y
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2. Persistent alcohol misuser in the past 3 years? Yes  No

(a) Is it controlled? Yes  No

3. Persistent misuse of drugs or other substances in the past 6 years? Yes  No

(a) If Yes, the type of substance(s) misused?

(b) Is it controlled? Yes  No

(c) Has the applicant undergone an opiate treatment programme? Yes  No

If Yes, give date started.

D	D	M	M	Y	Y
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**6 – SLEEP DISORDERS**

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

**IF NO, PLEASE GO TO 7 – OTHER MEDICAL CONDITIONS**  
**IF YES, PLEASE GIVE DIAGNOSIS AND ANSWER ALL QUESTIONS BELOW**

(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. Different measurements are not prescribed as this is a clinical issue. Please give details in 9 – FURTHER DETAILS**

**(b) Please answer questions (i) to (vi) for all sleep condition**

(i) Date of diagnosis. 

D	D	M	M	Y	Y
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(ii) Is it controlled successfully? Yes  No

(iii) If Yes, please state treatment.

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

(v) Please state period of control.  Years  Months

(vi) Date of last review. 

D	D	M	M	Y	Y
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## 7 – OTHER MEDICAL CONDITIONS

1. Is there a history or evidence of narcolepsy? Yes  No
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? Yes  No
- 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? Yes  No
- If Yes, is this the result of alcohol misuse?  
**IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS** Yes  No
7. Is there a history of renal failure?  
**IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS** Yes  No
8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?  
**IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS** Yes  No
9. Does any medication currently taken cause the applicant side effects that could affect safe driving? Yes  No
- IF YES, PLEASE FILL IN SECTION 8 – MEDICATION AND GIVE SYMPTOMS IN 9 – FURTHER DETAILS**
10. Does the applicant have any other medical conditions that could affect safe driving? Yes  No
- IF YES, PLEASE GIVE DETAILS IN 9 – FURTHER DETAILS**

## 8 – MEDICATION

**PLEASE PROVIDE DETAILS OF ALL CURRENT MEDICATION, INCLUDING EYEDROPS, CONTINUE ON A SEPARATE SHEET IF NECESSARY**

Medication		Dosage					
Reason for taking							
Approximate date started (if known)	D	D	Y	Y	M	M	

Medication		Dosage					
Reason for taking							
Approximate date started (if known)	D	D	M	M	Y	Y	

Medication		Dosage					
Reason for taking							
Approximate date started (if known)	D	D	M	M	Y	Y	

Medication		Dosage					
Reason for taking							
Approximate date started (if known)	D	D	M	M	Y	Y	

Medication		Dosage					
Reason for taking							
Approximate date started (if known)	D	D	M	M	Y	Y	

**9 – FURTHER DETAILS**

**PLEASE SEND US COPIES OF RELEVANT HOSPITAL NOTES. PLEASE DO NOT SEND ANY NOTES NOT RELATED TO FITNESS TO DRIVE. USE THE SPACE BELOW TO PROVIDE ANY ADDITIONAL INFORMATION, CONTINUE ON A SEPARATE SHEET IF NECESSARY**

**10 – CONSULTANTS DETAILS****PLEASE PROVIDE DETAILS OF TYPE OF SPECIALIST(S)/CONSULTANTS, INCLUDING ADDRESS, CONTINUE ON A SEPARATE SHEET IF NECESSARY**

Consultant In		Consultant In											
Reason for attendance		Reason for attendance											
Name		Name											
Address		Address											
Last Appointment Date	D	D	M	M	Y	Y	Last Appointment Date	D	D	M	M	Y	Y

**11 – ADDITIONAL INFORMATION**

Applicant's weight (kg)  Applicant's height (cm)

Details of smoking habits, if any

Number of alcohol consumed each week

**APPLICANT'S CONSENT AND DECLARATION****APPLICANT MUST COMPLETE THIS SECTION AND SIGN TO CONFIRM THE STATEMENTS BELOW**

Applicant's full name

Applicant's address

Date of Birth       Telephone Number

**I authorise my doctor and specialist(s) to release reports and information to Stockton-on-Tees Borough Council about my medical condition.**

**I authorise Stockton-on-Tees Borough Council to divulge relevant medical information about me to doctors and specialist(s) as necessary in the course of medical enquiries into my 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 and belief they are correct.**

Signature of applicant

Date

**NOTE ABOUT CONSENT**

You will see that we have asked for your consent, not only for the release of medical reports from your doctor, but also that we might in turn, very occasionally release medical information to doctors and specialists, either because we wish you to be examined, and the doctors/specialists need to know the medical details, or because we require further information.

**12 – EXAMINING DOCTOR’S DETAILS  
TO BE COMPLETED BY THE DOCTOR CARRYING OUT THE EXAMINATION**

**CERTIFICATE OF FITNESS TO DRIVE A  
PRIVATE HIRE/HACKNEY CARRIAGE VEHICLE**

Applicant’s full name

Date of birth

**PLEASE TICK ✓ ALL RELEVANT BOXES**

I certify that I am a registered medical practitioner who is competent in undertaking DVLA Group 2 medical examinations, and that I am familiar with the current requirements of Group 2 Medical Standards applied by the DVLA in the current version of the publication  
[www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals](http://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals)

I certify that I have physically examined the above applicant

I certify that I am the applicant’s own GP, or medical practitioner and confirm that I have access to the applicant’s **FULL** medical records/history not a summary prior to completion

I certify that I am **NOT** the applicant’s own GP, or medical practitioner and confirm that I have access to the applicant’s **FULL** medical records/history **NOT** a summary prior to completion, and that I can provide evidence of this access if required by Stockton-on-Tees Borough Council

**I CONSIDER THAT THE ABOVE APPLICANT (PLEASE TICK ✓ RELEVANT BOX)**

Meets the DVLA group 2 medical standards for vocational drivers and is **FIT** to drive a Private Hire or Hackney Carriage Vehicle to Group 2 Standards in accordance with:  
[www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals](http://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals)

Does not meet the DVLA group 2 medical standards for vocational drivers and is **UNFIT** to drive a Private Hire or Hackney Carriage Vehicle. In accordance with:  
[www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals](http://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals)

Name of medical practitioner							
Practice address							
Practice telephone number and email address							
GMC registration number							
Date of physical examination	D	D	M	M	Y	Y	
Date of visual examination	D	D	M	M	Y	Y	
Signature of medical practitioner							
Surgery stamp							