

# Medical Examination Report

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

### To the Applicant

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act 1976, to provide a Medical Examination Report to the effect that you are physically fit to drive a Private Hire/Hackney Carriage Vehicle.

This form is to be completed by your own GP or a GP who has access to your medical records and is for the confidential use of the Licensing Authority.

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

Upon reaching the age of 45 a Group 2 Medical Report is required every 5 years until the age of 65. From the age of 65 a Group 2 Medical Report is required every year.

This Medical report cannot be issued free of charge as part of the National Health Service. The applicant must pay the medical practitioner's fee, unless other arrangements have been made. The Licensing Authority accepts no liability to pay it.

### To the Medical Practitioner

The Local Government (Miscellaneous Provisions) Act 1976, enables the Council to require any applicant for a Hackney Carriage or Private Hire driver's licence to produce a certificate signed by a Registered Medical Practitioner, to the effect that the applicant is physically fit to be the driver of a Hackney Carriage or Private Hire vehicle. The Act does not prescribe any specific matters, which are to be taken into account by the Medical Practitioner who is asked to sign such a certificate.

When completing this medical report please have regard to the "Medical Standards of Fitness to Drive" and the current guidelines "At a Glance Guide to the Current Medical Standards of Fitness to Drive" issued regularly by the Drivers Medical Unit, DVLA Swansea. The Licensing Authority considers a Hackney Carriage/Private Hire driver to be Group 2 classification.

Only complete the Vision Assessment if you are able to fully and accurately complete ALL the questions. If you are unable to do this you must tell the applicant that they will need to arrange to have this part of the assessment completed by an Optician or Optometrist.

Once complete this form should then be returned to the applicant to submit with their application.

## 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).

1. **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) dioptres.

**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.

2. **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)
3. **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.
  4. **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
    - 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
    - Cancer of the lung

# Vision Assessment

**To be completed by a Doctor or Optician/Optomestrist**

Applicants Full Name		Date of Birth	
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Note: Visual acuities, as measured by the 6 metre Snellen Chart, must be a least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and a least 6/60 (decimal Snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to chieve this standard. A LogMAR reading is acceptable.

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 acuities **of each eye** in terms of the 6m Snellen chart.

**Uncorrected**

**Corrected (using prescription worn for driving)**

Right    
 Left    
 Right    
 Left

3. Please give the best binocular acuity with corrective lenses if worn for driving

4. If glasses were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptrres?      **Yes**      **No**

    

5. If a correction is worn for driving, is it well tolerated?           

**If you answer Yes to any of the following, give details in the box provided.**

6. Is there a history of any medical condition that may affect the applicants binocular field of vision (central and /or peripheral)?      **Yes**      **No**

    

7. Is there diplopia?              
 Is it controlled? If Yes, please give details in the box provided below           

8. Is there any reason to believe that there is impairment of contrast sensitivity or intolerance to glare?           

9. Does the applicant have any other ophthalmic condition?           

Details

Date of Examination	
Name (Print)	
Signature	
Date of Signature	
Your GOC, HPC or GMC Number	

Doctor/Optomestrist/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

### Applicant's Details

To be completed by your own Doctor or a Doctor who has access to your medical records.

Taking into account the criteria for Group 2 vocational drivers as set out in "Medical Aspects of Fitness to Drive" and the latest edition of the DVLA publication "At a Glance Guide for Current Medical Standard of Fitness To Drive"

#### Section 1 – Nervous System

	Yes	No
1. Has the applicant had any form of seizure? If NO, please go to question 2	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please answer questions (a) to (f)		
(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"/>
	Last Attack	<input type="text"/>
(c) Is the applicant currently on anti-epileptic medication? If YES, please fill in current medication in Section 8	<input type="checkbox"/>	<input type="checkbox"/>
(d) If no longer treated, please give date when treatment ended	<input type="text"/>	
(e) Has the applicant had a brain scan? If YES, please give details in Section 6	<input type="checkbox"/>	<input type="checkbox"/>
(f) Has the applicant had an EEG? If YES, to any of the above please supply reports if available	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the applicant suffer from narcolepsy or cataplexy? If YES, please give date(s) and details in Section 6	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there a history of, or evidence of ANY conditions listed at (a) to (h)? If YES, please give full details at Section 6 and supply relevant reports	<input type="checkbox"/>	<input type="checkbox"/>
(a) Stroke or TIA If YES, please give date	<input type="text"/>	
Has there been a full recovery?	<input type="checkbox"/>	<input type="checkbox"/>
Has a carotid ultra sound been undertaken?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Sudden and disabling dizziness/vertigo with the last year with a liability to recur	<input type="checkbox"/>	<input type="checkbox"/>
(c) Subarachnoid haemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
(d) Serious traumatic brain injury within the last 10 years	<input type="checkbox"/>	<input type="checkbox"/>

- |  |                          |                          |
|--|--------------------------|--------------------------|
| (e) Any form of brain tumour           | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <b>Yes</b>               | <b>No</b>                |
| (f) Other brain surgery or abnormality | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Chronic neurological disorders     | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Parkinson's disease                | <input type="checkbox"/> | <input type="checkbox"/> |

**Section Two – Diabetes Mellitus**

- |  | <b>Yes</b>   | <b>No</b>                |
|--|--|--------------------------|
| 1. Does the applicant have diabetes mellitus?  | <input type="checkbox"/>                                 | <input type="checkbox"/> |
| If NO, please go to Section 3  |  |                          |
| If YES, please answer the following questions.   |  |                          |
| 2. (a) Is the diabetes managed by Insulin?   | <input type="checkbox"/>                                 | <input type="checkbox"/> |
| If YES, please give date started on insulin  | <input style="width: 300px; height: 20px;" type="text"/> |                          |
| (b) If treated with insulin, are there a least 3 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.   |  |                          |
| (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"/> |
| (f) Diet only?   | <input type="checkbox"/>                                 | <input type="checkbox"/> |
| 3. (a) Does the applicant test blood glucose at least twice every day?   | <input type="checkbox"/>                                 | <input type="checkbox"/> |
| (b) Does the applicant test at times relevant to driving?  | <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"/> |
| 4. Is there any evidence of impaired awareness of hypoglycaemia?   | <input type="checkbox"/>                                 | <input type="checkbox"/> |
| 5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?       | <input type="checkbox"/>                                 | <input type="checkbox"/> |
| 6. Is there evidence of:   |  |                          |
| (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 to 6 above, please give details in Section 6.  |  |                          |
| 7. Has there been laser treatment or intra-vitreous treatment for retinopathy?                                 | <input type="checkbox"/>                                 | <input type="checkbox"/> |

If YES, please give dates of treatment  
**Section 3 – Psychiatric Illness**

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

- Please enclose relevant hospital notes
- If applicant remains under specialist clinic(s), ensure details are filled in at Section 7.

	Yes	No
1. Significant psychiatric disorder within the past 6 months	<input type="checkbox"/>	<input type="checkbox"/>
2. Psychosis or hypomania/mania within the past 3 years, including psychotic depression	<input type="checkbox"/>	<input type="checkbox"/>
3. Dementia or cognitive impairment	<input type="checkbox"/>	<input type="checkbox"/>
4. Persistent alcohol misuse in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
5. Alcohol dependence in the past 3 years	<input type="checkbox"/>	<input type="checkbox"/>
6. Persistent drug misuse in the past 12 months	<input type="checkbox"/>	<input type="checkbox"/>
7. Drug dependence in the past 3 years	<input type="checkbox"/>	<input type="checkbox"/>

If YES to ANY of questions 4 to 7 please state how long this has been controlled

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

## Section 4 – Cardiac

### Section 4A – Coronary Artery Disease

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

If NO, go to Section 4B

If YES, please answer all questions below and give details at Section 6, enclose relevant hospital notes

1. Has the applicant suffered from Angina?  Yes  No

If YES, please give the date of last known attack

2. Acute coronary syndromes including Myocardial infarction?  Yes  No

If YES, please give date

3. Coronary angioplasty (P.C.1)?  Yes  No

If YES, please give most recent intervention

4. Coronary artery by-pass graft surgery?  Yes  No

If YES, please give date

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**Section 4B – Cardiac Arrhythmia**

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

If NO, go the Section 4C

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

1. Has there been a significant disturbance or cardiac rhythm? i.e. Sinusoidal 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 (CRST-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?

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**Section 4C – Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection**

Is there a history or evidence of ANY of the following? Yes  No

If No, go to Section 4D

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

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?

3. Aortic aneurysm

If YES,

(a) Site of Aneurysm: Thoracic  Abdominal

(b) Has it been repaired successfully?

(c) Is the transverse diameter currently >5.5cm?

(d) If NO, please provide latest measurement and date obtained

4. Dissection of the aorta repaired successfully



If YES, please provide copies of reports to include those dealing with any surgical treatment.

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | <b>Yes</b>               | <b>No</b>                |
| 5. Is there a history of Marfan's disease? | <input type="checkbox"/> | <input type="checkbox"/> |

If YES, please provide relevant hospital notes

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#### Section 4D – Valvular/Congenital Heart Disease

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>Yes</b>               | <b>No</b>                |
| Is there a history of, or evidence of, valvular/congenital heart disease? | <input type="checkbox"/> | <input type="checkbox"/> |

If NO, go to Section 4E

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

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Is there a history of congenital heart disorder?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is there a history of heart valve disease?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is there any history of embolism? (not pulmonary embolism)                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the applicant currently have significant symptoms?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has there been any progression since the last licence application? (if relevant) | <input type="checkbox"/> | <input type="checkbox"/> |

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#### Section 4E – Cardiac Other

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>Yes</b>               | <b>No</b>                |
| Does the applicant have a history of ANY fo the following conditions: | <input type="checkbox"/> | <input type="checkbox"/> |

If NO, go to Section 4F

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

- |   |                          |                          |
|---|--------------------------|--------------------------|
| (a) a history of, or evidence of, heart failure?                | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) established cardiomyopathy?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) has a Left Ventricular Assist Device (LVAD) been implanted? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) untreated atrial myxoma                                     | <input type="checkbox"/> | <input type="checkbox"/> |

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#### Section 4F – Cardiac Investigations

**This section must be completed for all applicants**

- |                                       |                          |                          |
|---------------------------------------|--------------------------|--------------------------|
|                                       | <b>Yes</b>               | <b>No</b>                |
| 1. Has a resting ECG been undertaken? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, does it show:-                |                          |                          |
| (a) pathological Q waves              | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) left bundle branch block?         | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) right bundle branch block?        | <input type="checkbox"/> | <input type="checkbox"/> |

If YES, to any of the above please provide a copy of the relevant ECG report or comment at Section 6.

- |  |                          |                          |  |
|--|--------------------------|--------------------------|--|
|  | <b>Yes</b>               | <b>No</b>                |  |
| 2. Has an exercise ECG been undertaken (or planned)?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| If YES, please give date and details in Section 6.<br>Please provide relevant reports if available |                          |                          |  |
| 3. Has an echocardiogram been undertaken (or planned)?   | <input type="checkbox"/> | <input type="checkbox"/> |  |
| (a) If YES, please give date and details in Section 6  |                          |                          |  |
| (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%                  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 4. Has a coronary angiogram been undertaken (or planned)?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| If YES, please give date and details in Section 6  |                          |                          |  |
| 5. Has a 24 hour ECG tape been undertaken (or planned)?  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| If YES, please give date and details in Section 6  |                          |                          |  |
| 6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?              | <input type="checkbox"/> | <input type="checkbox"/> |  |
| If YES, please give date and details in Section 6  |                          |                          |  |

**Section 4G – Blood Pressure**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1. Please record today's blood pressure reading                  |                          |                          |
| 2. Is the applicant on anti-hypertensive treatment?              | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, provide three previous readings with dates, if available |                          |                          |

Date	Reading

**Section 5 – General**

Please answer All questions. If YES to any question please give full details in Section 6.

- |   |                          |                          |  |
|---|--------------------------|--------------------------|--|
|   | <b>Yes</b>               | <b>No</b>                |  |
| 1. Is there currently any functional impairment that is likely to affect control of the vehicle?                                  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| 2. Is there a history of bronchogenic carcinoma or other malignant tumour With a significant liability to metastasise cerebrally? | <input type="checkbox"/> | <input type="checkbox"/> |  |

3. Is there any illness that may cause significant fatigue or cachexia that affect safe driving?
4. 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?
5. Does the applicant have a history of liver disease of any origin?
6. Is there a history of renal failure?
7. (a) Is there a history of, or evidence of, obstructive sleep apnoea syndrome?
- (b) Is there any other other medical condition causing excessive daytime sleepiness?
- If YES, please give diagnosis
- If YES, to 7a or b 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?
11. Does the applicant have any other medical conditions that could affect safe driving?

**Section 6 – Further Details**

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

**Section 7 – Consultants’ Details**

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

Consultant In	Consultant In
Name	Name
Address	Address
Date of Last Appointment:	Date of Last Appointment:

**Section 8 – Medication**

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

<b>Medication</b>	<b>Dosage</b>
<b>Reason for taking:</b>	

<b>Medication</b>	<b>Dosage</b>
<b>Reason for taking:</b>	

<b>Medication</b>	<b>Dosage</b>
<b>Reason for taking:</b>	

<b>Medication</b>	<b>Dosage</b>
<b>Reason for taking:</b>	

<b>Medication</b>	<b>Dosage</b>
<b>Reason for taking:</b>	

<b>Medication</b>	<b>Dosage</b>
<b>Reason for taking:</b>	

### Section 9 – Additional Information

Applicant's weight(kg)	<input type="text"/>
Height (cms)	<input type="text"/>
Details of smoking habits, if any	<input type="text"/>
Number of alcohol units taken each week	<input type="text"/>

### Applicant's Consent And Declaration

Applicant's Full Name:			
Applicant's Address:			
Telephone Number	<input type="text"/>	Date of Birth	<input type="text"/>

I authorise my Doctor and Specialist(s) to release reports 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 Specialists(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 they are correct.

Signature of Applicant	<input type="text"/>
Date	<input type="text"/>

### Note About Consent

You will see that we have asked for your consent, not only for the release of medical reports from your doctors, 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 need to know the medical details, or because we require further information.

**Section 10 – Examining Doctor’s Details**

To be completed by the doctor carrying out the examination.

## Certificate Of Fitness To Drive A Private Hire Or Hackney Carriage Vehicle

**Applicant Name:**

**Date of Birth:**

*Please tick as appropriate*

I am a registered Medical Practitioner who is competent in undertaking DVLA Group 2 Medical Examinations.

I have today examined the above applicant and I confirm that I have access to the applicant’s **FULL** Medical Records/History.

I have examined the applicant medically to the DVLA Group 2 Medical Standards for Vocational Drivers and had regard to the DVLA’s “At a Glance” and the Medical Commission on Accident Preventions booklet “Medical Aspects of Fitness to Drive”.

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 Private Hire or Hackney Carriage Vehicle to Group 2 Standards

Does not meet the DVLA group 2 medical standards for vocational drivers and is **UNFIT** to drive a Private Hire or Hackney Carriage Vehicle

**Doctors Details**

Name	
Address	
Telephone Number	
E-Mail Address	
GMC Registration Number	

Signature of Medical Practitioner	
Date of Examination	

Surgery Stamp