

## Application To Drive Private Hire/Hackney Carriage Vehicles

Please read the attached guidance notes before completing this application form.

Title	Mr		Mrs		Miss		Ms		Other (Please State)	
Surname										
Forename(s)										
Maiden Name (If applicable)										
Have you ever spelt your name another way or used a variation of your name? If Yes, please give details of all variations										
Full Postal Address										
Date of Birth					Place of Birth					
Telephone Number		Home:				Mobile:				
E-Mail Address										
National Insurance Number										

Apply for a licence to drive

**PRIVATE HIRE VEHICLES**

**HACKNEY CARRIAGE VEHICLES**

**(Please Tick The Appropriate Box Or Both If You Require A Combined Licence)**

and provide the following information

Length of Residence at Current Address			
Previous Address if less than five years			
Length of Residence at Previous Address			
DVLA Driving Licence Number			
Expiry Date of DVLA Licence			
How Long have you held a Full Driving Licence (Applicants must have held a full driving licence for at least one year)			
Date Passed DSA Taxi Test		DSA Pass Certificate Number	

If you hold or have held a Hackney Carriage, Private Hire, PCV or HGV licence please give details

	Licence Number	Date of Expiry	Issued By	Length of Time Licence Held		
Hackney Carriage Licence						
Private Hire Licence						
PCV Licence						
HGV Licence						
Have you ever had a licence to drive any of the above vehicles refused, revoked or suspended?			YES		NO	
If YES, please give details						
Have you any physical infirmity, which might prevent you assisting passengers in a wheelchair or with luggage?			YES		NO	
If YES, please give details						

I have the right to work in the United Kingdom and I have attached the relevant documents (See guidance notes)	YES		NO	
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Date Safeguarding Awareness Training Completed		Certificate Enclosed	Yes	No
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If my application is successful I would like my licence to be granted for

**One Year**

**Three Years**

### Share Your Driving Licence Details (Check Code)

In order to determine if you are fit and proper the Council need to assess your driving record to confirm that you have a valid licence entitling you to drive in the UK and to verify any endorsements imposed on you by the DVLA. You must, prior to submitting your application, log onto the website: <https://www.gov.uk/view-driving-licence> and follow the instructions to share your licence with us within 21 days before you submit your application.

In the last 21 days I have logged onto <https://www.gov.uk/view-driving-licence> and created a code which I have written below to allow the Council to check my DVLA driving licence details (the code is case sensitive, please write it exactly as it appears on screen )

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We will be unable to process your application until confirmation of your DVLA licence has been supplied. Please see attached guidance leaflet for further information.



### How we collect and use information

#### Data Protection Act 2018

#### General Data Protection Regulations (GDPR)

The information you have provided will be held in accordance with Data Protection regulations. The data we hold will be kept and used in accordance with statutory requirements and may be disclosed to others within the Council and to other, external organisations, but only in order to ensure compliance with relevant legislation or for identification purposes or to prevent or detect fraud or a crime. For more information on how we use your personal data please visit our website at [www.stockton.gov.uk/dataprivacy](http://www.stockton.gov.uk/dataprivacy).

# DECLARATION

This declaration relates to **all offences including motoring offences**. Please ensure that you have read the guidelines on Relevance of Convictions. You must declare **all** relevant Convictions, Cautions, Reprimands, or Final Warnings that are not protected.

I (Insert Full Name)	
Of (Insert Full Address)	
Date of Birth	

## History

Have you ever been convicted for any Offence or received a Caution, Reprimand or Final Warning issued by the Police, Local Authority or other statutory enforcement body?

 **Yes**
 **No**

If yes please give full details below:

Date	Offence/Caution/Reprimand or Final Warning	Court/Police Force	Sentence

Are you aware of any enquiry/investigation being made at the present time by the Police or any Local Authority involving you?

 **Yes**
 **No**

If yes please give full details below:

Name of Police Force or Local Authority	Details of Investigation/Enquiry

Have you ever had any summons served on you for any offence(s) by the Police or any Local Authority?

 **Yes**
 **No**

If yes please give full details below:

Name of Police Force or Local Authority	Details of Investigation/Enquiry	Future Hearing Date

**I understand that the Council will share information relating to safeguarding, public safety and other disciplinary matters with other Council Services and other organisations.**

**I understand that the Council may contact DVLA in order to verify my driving licence details at any time, and I hereby give my authority enabling the Council to carry out such checks.**

**I do not wish to exclude myself from carrying children and/or vulnerable persons on a regular basis as defined by the DBS guidance.**

**For at least 3 years prior to the date hereof I have held a licence (not being a provisional licence) under Part III of the Road Traffic Act 1972 authorising me to drive a motor car.**

**I declare to the best of my knowledge and belief the answers given on this form are true.**

**If a licence is granted I undertake to comply with the conditions attached on the grant of the licence, relevant byelaws and legislation.**

<b>Signature of Applicant</b>	
<b>Date of Signature</b>	

### **Please Read Notes Before Signing**

Applicants should note that it is an offence for the person completing this form to make a false statement or omit relevant details.

#### **Disclosure Requirements**

On 29 May 2013, amendments were made to the Rehabilitation of Offenders Act (Exceptions) Order 1975 (the Order) so that certain old and minor cautions and spent convictions are 'protected' and are not subject to disclosure under the Exceptions Order, nor will they appear on a standard or enhanced disclosure certificate issued by the DBS.

Applicants for driver licences are required to disclose all convictions cautions, final warnings and reprimands whether they are spent or not, unless they are protected under the Order.

The information you give will be treated in confidence and will only be taken into account in relation to your application.

You should be aware that the licensing authority is empowered in law to check with the Disclosure and Barring Service (DBS) for the existence and content of any criminal record held in the name of the applicant. Information received from the DBS will be kept in strict confidence while the licensing process takes its course and will be retained for no longer than is necessary.

The disclosure of a criminal record or other information does not debar applicants from obtaining a licence unless the Council considers that the applicant is not a fit and proper person. In making this decision the Council will consider the nature of the offence(s), caution, warning or reprimand, the period since conviction(s), at what age the offences were committed and any other relevant factors. Any applicants refused a driver's licence on the grounds that he/she is not a fit and proper person to hold such a licence has a right of appeal to a Magistrates' Court. (For further information see Guidance Leaflet – Relevance of Convictions)

## **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 Medical Examination Report is to be completed by your own GP, or a GP who has access to your **FULL** 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 the 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 Examination 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.

The Medical Examination Report must be completed in full by the applicant's own GP, or a medical practitioner who has **FULL** access to the applicant's medical records prior to completion. Please answer all questions and once completed, please sign the declaration at the end.

Stockton-on-Tees Borough Council's policy on medical fitness requires that taxi drivers meet Group 2 Entitlement, as set out in the DVLA publication 'A Guide to the current Medical Standards of Fitness to Drive'. This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to taxi drivers.

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 completed, this Medical Examination Report should 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).

**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.
- 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 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, the 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? Yes  No   
**Please indicate below and give full details in Q7 below.**

(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 below.**

Yes  No

7. Details or additional information.

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**EXAMINING DOCTOR/OPTICIAN'S DETAILS**

Name of examining doctor or optician undertaking vision assessment	
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Company or practice address	
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Company or practice contact number	
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Company or practice email address	
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Your GOC or GMC number	
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Signature of examining doctor or optician	
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Date of signature	D	D	M	M	Y	Y
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Doctor/optometrist/optician's stamp
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# 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, 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".

**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 | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 5. Subarachnoid haemorrhage (non-traumatic)?  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 6. Significant head injury within the last 10 years?                                    | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 7. Any form of brain tumour?  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 8. Other intracranial pathology?  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 9. Chronic neurological disorder(s)?  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 10. Parkinson's disease?  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 11. Blackout, impaired consciousness or loss of awareness within the last 10 years?     | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

## 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 | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| <b>If No, go to 1c.</b>  |     |                          |    |                          |   |   |   |  |  |
| If Yes, please give date started on insulin.   |     |                          |    |                          |   |   |   |  |  |
|  |     | D                        | D  | M                        | M | Y | Y |  |  |
| (b) Are there a least 3 months of blood glucose readings stored on a memory meter or meters?   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| <b>If No, please give details in 9 – FURTHER DETAILS.</b>  |     |                          |    |                          |   |   |   |  |  |
| (c) Other injectable treatments?   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| (d) A Sulphonyl urea or a Glinide?   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| (e) Oral hypoglycaemic agents and diet?  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| <b>If Yes to any of (a) to (e), please fill in the medication in 8 – MEDICATION.</b>   |     |                          |    |                          |   |   |   |  |  |
| (f) Diet only?   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| 2. (a) Does the applicant test blood glucose at least twice every day?   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| (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 | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| (c) Does the applicant keep fast-acting carbohydrate within easy reach when driving?   | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |
| (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?  | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |   |   |   |  |  |

3. (a) Has the applicant ever had a hypoglycaemic episode? Yes  No
- (b) 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
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**3 – CARDIAC**

**3A – CORONARY ARTERY DISEASE**

- 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
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2. Acute coronary syndromes including myocardial infarction? Yes  No

If Yes, please give date.

D	D	M	M	Y	Y
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3. Coronary angioplasty (PCI)? Yes  No

If Yes, please give date of most recent intervention.

D	D	M	M	Y	Y
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4. Coronary artery bypass graft surgery? Yes  No

**If Yes, please give date.**

D	D	M	M	Y	Y
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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.**

**SECTION 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 If Yes; Yes  No

(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 INVESTIGATIONS.**  
**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.**

### SECTION 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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	/	
--	---	--

D	D	M	M	Y	Y
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	/	
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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), (c) 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
---	---	---	---	---	---

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

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

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

#### 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? If Yes, please confirm condition below. Yes  No
- 
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
---	---	---	---	---	---
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
---	---	---	---	---	---

**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
---	---	---	---	---	---

(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
---	---	---	---	---	---



## 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.**
7. Is there a history of renal failure? Yes  No   
**If Yes, please give details in 9 – FURTHER DETAILS.**
8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes  No   
**If Yes, please give details in 9 – FURTHER DETAILS.**
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)	<input type="text"/> D <input type="text"/> D <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M

Medication	Dosage
Reason for taking	
Approximate date started (if known)	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> 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**

**YOU 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.

**SECTION 10 – EXAMING 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 ✓ APPROPRIATE 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 “At a Glance Guide to the Current Medical Standards of Fitness to Drive”.

I certify that I have today examined the above applicant and I confirm that I have access to the applicant’s **FULL** medical records/history.

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.

Name of medical practitioner

Practice address

Practice contact number

Practice email address

GMC registration number

Signature of medical practitioner

Date of examination 

D	D	M	M	Y	Y
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Surgery stamp