Stockton-on-Tees
BOROUGH COUNCIL

Licensing Service
Municipal Buildings
Church Road
Stockton-on-Tees
TS18 1LD

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) dioptres.

Visual Field – The horizontal visual field should be a least 160 degrees; the extension should be a 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 attach (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

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 ia 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 lendes 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 opthalmic condition? **If Yes, please give full details in Q7 below.** | Yes | | No | |

7. Details or additional information.

EXAMINING DOCTOR/OPTICAN'S DETAILS

Name of examining doctor or optician undertaking vision assessment	
Company or practice address	
Company or practice contact number	
Company or practice email address	
Your GOC or GMC number	
Signature of examining doctor or optician	
Date of signature	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, 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

   Last episode D D M M Y Y

   (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

   (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

   (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

   (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

   (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 ☐

(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.

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-vitreal treatment for retinopathy? Yes ☐ No ☐

If Yes, please give most recent date of treatment. D D M M Y Y

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

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.

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

   (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;

   (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

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? Yes ☐ No ☐
   If Yes, please provide relevant reports (including echocardiogram).
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. ___ / ___

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

___ / ___	D D M M Y Y	
___ / ___	D D M M Y Y	
___ / ___	D D M M Y Y	

3. Is there a history of malignant hypertension? Yes ☐ No ☐

If Yes, please 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

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 sychotic depression? Yes ☐ No ☐

3. (a) Dementia or congnitive 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 eveidence 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 servere 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? **If Yes, please give details in 9 – FURTHER DETAILS.**	Yes		No

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)	

Detials 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	D D M M Y Y	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	D D M M Y Y

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 sppecialists, 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
Surgery stamp	