

City of Wolverhampton Council Licensing Services**Hackney Carriages and Private Hire Vehicle Driver Medical Certificate****Full Name of Applicant (Capitals)** _____**Address:** _____ **Postcode** _____

I hereby authorise my doctor(s) and specialists to release reports/medical information to the Medical Practitioner, should they require further information about condition(s) relevant to my fitness to drive to group 2 standard.

Signature of applicant _____

(To be signed in the presence of the medical practitioner signing this certificate)

You are Assessing Fitness to Drive at DVLA Group 2 Standard, a guidance for medical professionals is available online at <https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals>

This medical must be completed in person and not remotely. **You must include the full Group 2 Medical Assessment completed with this document for clarification.**

The applicant has provided one from each type of the following forms of identification,

Type 1: Passport Driving Licence **Type 2:** Utility Bill (gas, electric, telephone, water) Bank Statement Birth Certificate Marriage/Civil Partnership Certificate: **Date of Birth of applicant** ____/____/____ **Age of applicant** _____**Medical certification frequency requirement**

- A new certificate must be produced every 5 years after the applicant's 45th birthday.
- Once the age of 65 is reached, a medical certificate must be produced every year.

Earlier medical certification frequency requirement

The above medical certification frequency is not sufficient: (tick box **if applicable**) and I recommend that the applicant is examined no later than: (insert date) _____

I certify that I have on this day examined the applicant, who signed this form in my physical presence and showed two forms of identification as indicated above and they have provided me with their full medical records obtained within the last month for which I have reviewed to ascertain their medical fitness to Group 2 Standards and completed the attached D4 Form and I declare that they meet the below:

Medically Fit **Medically unfit** to drive a hackney carriage or private hire vehicle.

Name of GMC registered Medical Practitioner _____**Signature of GMC registered Medical Practitioner** _____ **Date** ____/____/____.**GMC Reference Number**

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Please add address and phone number
or Medical Practice Address Stamp
No disclaimers are acceptable.

3 Cardiac

a Coronary artery disease

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

If No, go to section 3b, Cardiac arrhythmia

If Yes, please answer all questions below and enclose relevant hospital notes.

1. Has the applicant ever had an episode of angina? Yes No

If Yes, please give the date of the last known attack.

2. Acute coronary syndrome including myocardial infarction? Yes No

If Yes, please give date.

3. Coronary angioplasty (PCI)? Yes No

If Yes, please give date of most recent intervention.

4. Coronary artery bypass graft surgery? Yes No

If Yes, please give date.

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? Please give details below. Yes No

b Cardiac arrhythmia

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

If No, go to section 3c, Peripheral arterial disease

If Yes, please answer all questions below and enclose relevant hospital notes.

1. Has there been a significant disturbance of 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 a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes No

If Yes:

(a) Please give date of implantation.

(b) Is the applicant free of the symptoms that caused the device to be fitted?

(c) Does the applicant attend a pacemaker clinic regularly?

c 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 or dissection? Yes No

If No, go to section 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 to undertake 9 minutes of the standard Bruce Protocol ETT?

3. Aortic aneurysm? Yes No

If Yes:

(a) Site of aneurysm: Thoracic
 Abdominal

(b) Has it been repaired successfully?

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

cm

4. Dissection of the aorta repaired successfully? Yes No
 If Yes, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? Yes No
 If Yes, please provide relevant hospital notes.

d Valvular/congenital heart disease

Is there a history or evidence of valvular or congenital heart disease? Yes No

If No, go to section 3e, Cardiac other

If Yes, answer all questions below and provide 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? Yes No

Applicant's full name

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Date of birth

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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6 Sleep disorders

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

If No, go to section 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. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9 page 7, Further details.

- b) Please answer questions (i) to (vi) for **all** sleep conditions.

(i) Date of diagnosis: Yes No

(ii) Is it controlled successfully?

(iii) If Yes, please state treatment.

(iv) Is applicant compliant with treatment? Yes No

(v) Please state period of control:

years months

(vi) Date of last review.

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 section 9, page 7.

7. Is there a history of renal failure? Yes No

If Yes, please give details in section 9, page 7.

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? 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 section 9, page 7.

10. Does the applicant have any other medical condition that could affect safe driving? Yes No

If Yes, please provide details in section 9, page 7.

8 Medication

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

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

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

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Reason for taking:	
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Applicant's full name

Date of birth

The applicant must fill in this page

Applicant's declaration

You **must** fill in this section and **must not** alter it in any way.

Please read the following important information carefully then sign to confirm the statements below.

Important information about fitness to drive

As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.

These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.

Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory panel members.

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.

I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.

Name

Signature

Date

I authorise the Secretary of State to correspond with medical professionals via electronic channels (fax and/or email)

Yes No

Checklist

- Have you signed and dated the declaration? **Yes**
- Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed? **Yes**

Important

This report is valid for 4 months from the date the doctor, optician or optometrist signs it.

Please return it together with your application form.