

## Certificate of fitness to drive a hackney carriage or private hire vehicle

### Information for medical professionals

When completing this medical assessment and certificate, please have regard to the DVLA's "*Assessing fitness to drive - a guide for medical professionals*" which gives further advice on Group 2 standards. The main purpose of the medical assessment is to determine whether or not the applicant is fit to drive in accordance with the DVLA Group 2 medical standards for vocational drivers. Additional information should only be disclosed where it is relevant to the applicant's fitness to drive and forms part of this medical assessment.

APPLICANT NAME:	
ADDRESS:	
DATE OF BIRTH:	

Is the applicant registered with your medical practice? YES / NO

Did you have access to the applicant's full medical records when undertaking this assessment? YES / NO

***If you have answered "No" to both questions you cannot undertake this assessment for NHDC***

Being a resistered medical practitioner who is competent in undertaking DVLA Group 2 medical examinations, I have today examined the above applicant. I have examined the applicant medically to DVLA Group 2 medical standards for vocational drivers and have had access to the applicant's full medical records and I consider the above applicant\*:

\* Please tick the relevant box

Meets the DVLA Group 2 medical standards for vocational drivers and is **FIT** to drive a hackney carriage or private hire vehicle

Does not meet the DVLA Group 2 medical standards for vocational drivers and is **UNFIT** to drive a hackney carriage or private hire vehicle

Signed:

Name:  (Block Capitals)

Date:







**1 Neurological disorders**

Please tick ✓ the appropriate boxes  
Does the applicant have a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)?  
**If no, go to section 2, Diabetes mellitus**  
If yes, please answer all questions below.

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 1. Has the applicant had any form of seizure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) Has the applicant had more than one seizure episode?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Please give date of first and last episode.  |                          |                          |
| First episode  | DDMMYY                   |                          |
| Last episode   | DDMMYY                   |                          |
| (c) Is the applicant currently on anti-seizure medication?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) If no longer treated, when did treatment end?  | DDMMYY                   |                          |
| (e) Has the applicant had a brain scan?<br>If yes, please give details in section 9, page 6.             | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has the applicant experienced any dissociative/functional seizures?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) If yes, please give date of most recent episode.   | DDMMYY                   |                          |
| (b) If yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Stroke or TIA?  | Yes                      | No                       |
| If yes, give date.   | DDMMYY                   |                          |
| (a) Has there been a <b>full</b> recovery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Has a carotid ultrasound been undertaken?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) If yes, was the carotid artery stenosis >50% in either carotid artery?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Is there a history of multiple strokes/TIAs?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Subarachnoid haemorrhage (non-traumatic)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Significant head injury within the last 10 years?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Any form of brain tumour?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other intracranial pathology?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Chronic neurological disorder(s)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Parkinson's disease?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Blackout, impaired consciousness or loss of awareness within the last 5 years?                       | <input type="checkbox"/> | <input type="checkbox"/> |

**2 Diabetes mellitus**

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | Yes                      | No                       |
| Does the applicant have diabetes mellitus?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If no, go to section 3, Cardiac</b>  |                          |                          |
| If yes, please answer all questions below.  |                          |                          |
| 1. Is the diabetes treated by:  | Yes                      | No                       |
| (a) Insulin?  | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, go to 1c   |                          |                          |
| If yes, please give date started on insulin.  | DDMMYY                   |                          |
| (b) Are there at least 6 continuous weeks of blood glucose readings stored on a memory meter or meters?   | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, please give details in section 9, page 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"/> |
| 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 whilst driving)? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Does the applicant keep fast-acting carbohydrate within easy reach whilst 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"/> |
| 3. (a) Has the applicant ever had a hypoglycaemic episode?  | Yes                      | No                       |
| (b) Is there full awareness of hypoglycaemia?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?  | Yes                      | No                       |
| If yes, please give details and dates below.  |                          |                          |
|   | [Empty box for details]  |                          |
|   | DDMMYY                   |                          |
|   | DDMMYY                   |                          |
|   | DDMMYY                   |                          |
| 5. Has there been laser treatment or intra-vitreous treatment for retinopathy?  | Yes                      | No                       |
| If yes, please give most recent date of treatment.  | DDMMYY                   |                          |

Applicant's full name	[Grid for name]	Date of birth	DDMMYY
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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 6, Further details.

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

(i) Date of diagnosis:         Yes No

(ii) Is it controlled successfully?

(iii) Is applicant compliant with treatment?

(iv) Date of last review.

## 7 Other medical conditions

1. Is there a history or evidence of narcolepsy? Yes No

2. Is there any impairment resulting from either a physical or non-physical medical condition which is likely to affect the ability to control a vehicle? Yes No

If yes, please provide information in section 9, page 6.

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. 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 6.

6. Is there a history of renal failure? Yes No  
   
 If yes, please give details in section 9, page 6.

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes No

8. Does the applicant have any other medical condition that could affect safe driving? Yes No  
   
 If yes, please provide details in section 9, page 6.

## 8 Medication

Is the applicant currently prescribed any of the following medication:

(a) Anti-seizure?

(b) Clozapine?

(c) Sulphonylurea or a Glinide?

(d) Insulin?

## 9 Further details

Do not send any notes not related to fitness to drive.

Use the space below to provide any additional information.

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 enquiries into your fitness to drive, we (DVLA) may need 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](http://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 (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.**