MEDICAL REPORT FOR A HACKNEY CARRIAGE AND PRIVATE HIRE VEHICLE DRIVER'S LICENCE

LOCAL GOVERNMENT (MISCELLANEOUS PROVISIONS) ACT 1976

NOTE FOR THE APPLICANT:

The applicant must pay the medical practitioner's fee unless other arrangements have been made. **The Licensing Authority accepts no liability to pay it.**

This medical must be completed by a GP who you are registered with and has access to all of your medical history.

Holders of a current PSV and/or HGV Licence will not be required to undergo a further medical examination if they are able to produce a medical report that is not more than **one month old.**

Applicants Details

Full Name:		
	Forenames	Surname

Permanent Address:
Date of Birth:
Home or Business Telephone Number:
Mobile Telephone Number:
Email Address:

NOTES FOR THE COMPLETING DOCTOR – **PLEASE READ THESE NOTES BEFORE UNDERTAKING THE EXAMINATION**

1. Before commencement please ensure that you have the patient's full medical records and not just a summary. If the surgery does not have this required information, please postpone the appointment.

2. The completed and signed form should then be given to the applicant who will forward this to the Licensing Authority.

3. The medical fitness standard adopted by the Licensing Authority for such licence holders reflects the fitness standard for **Group 2 DVLA** drivers. This is a higher standard than that required by ordinary car drivers. Guidance can be located at www.gov.uk/government/uploads/system/uploads/attachment_data/file/670819/assessing-fitness-to-drive-a-guide-for-medical-professionals.pdf

4. Where appropriate please provide as much detail as possible with relevant questions. In addition where specific medical investigations have taken place (e.g. exercise cardiac testing, echocardiography, EEG) or where relevant specialist reports (e.g. outpatient or discharge reports) are available then copies of these should accompany the application form. Failure to do so may delay the application process.

If you have any questions or queries please do not hesitate to contact the licensing team on the below details:

Licensing Service, PO BOX 883, Civic Centre, Newport, South Wales, NP20 4UR
Telephone Number: 01633 656656
Email: environment.licensing@newport.gov.uk

MEDICAL EXAMINATION

Please answer all questions

TO BE COMPLETED BY THE DOCTOR

SECTION 1 VISION

(a) Is the visual acuity as measured by the Snellen chart AT LEAST 6/9 in the better eye and AT LEAST 6/12 in the other? (Corrective lenses may be worn). YES ☐ NO ☐

(b) If corrective lenses have to be worn to achieve this standard

(i) Is the UNCORRECTED acuity at least 3/60 in the RIGHT eye? YES ☐ NO ☐

(ii) Is the UNCORRECTED acuity at least 3/60 in the LEFT eye? YES ☐ NO ☐

(3/60 being the ability to read the 60 lines of the snellen chart at 3 metres)

(c) Please state all the visual acuities for all applicants:

UNCORRECTED		CORRECTED (If applicable)	
Right	Left	Right	Left

(d) If there is NO perception of light in one eye, on what date did the applicant become monocular or lose the sight in one eye: Date: ☐

(e) Is there a full binocular field of vision? (central and/or peripheral) YES ☐ NO ☐

(f) Is there uncontrolled diplopia? YES ☐ NO ☐

SECTION 2 NERVOUS SYSTEM

		YES	NO
(a)	Has the applicant had major or minor epileptic seizure(s)?	☐	☐
	(i) Please give details of last seizure ☐		
	(ii) Please give date when treatment ceased ☐		
(b)	Is there a history of blackouts or impaired consciousness within the past 5 years?	☐	☐
(c)	Is there a history of stroke or TIA within the past 5 years?	☐	☐
(d)	Is there a history of sudden disabling dizziness/vertigo with the last year?	☐	☐
(e)	Is there a history of chronic and/or progressive neurological disorder? If YES, please give details in SECTION 7	☐	☐
(f)	Is there a history of brain surgery? If YES, please give details in SECTION 7	☐	☐
(g)	Is there a history of serious head injury?	☐	☐

If YES, please give details in SECTION 7

(h) Is there a history of brain tumour, either benign or malignant, primary or secondary? ☐ YES ☐ NO
If YES, please give details in SECTION 7

SECTION 3 DIABETES MELLITUS

	YES	NO
(a) Does the applicant have diabetes mellitus? If YES, please answer the following questions.	☐	☐
If NO, proceed to SECTION 4.		
(b) Is the diabetes managed by:-		
(i) Insulin? If YES, date started on Insulin ☐	☐	☐
(ii) Oral hypoglycaemic agents and diet?	☐	☐
(iii) Diet only?	☐	☐
(c) Is the diabetic control generally satisfactory?	☐	☐
(d) Is there evidence of :-		
(i) Loss of visual field?	☐	☐
(ii) Has there been bilateral laser treatment? If YES please give date ☐	☐	☐
(iii) Severe peripheral neuropathy?	☐	☐
(iv) Significant impairment of limb function or joint position sense?	☐	☐
(v) Significant episodes of hypoglycaemia?	☐	☐
(vi) Complete loss of warning symptoms of hypoglycaemia?	☐	☐

SECTION 4 PSYCHIATRIC ILLNESS

	YES	NO
(a) Has the applicant suffered from or required treatment for a psychosis in the past 3 years? If YES, please give details in SECTION 7	☐	☐
(b) Has the applicant required treatment for any other psychiatric disorder within the past 6 months? If YES, please give details in SECTION 7	☐	☐
(c) Is there confirmed evidence of dementia?	☐	☐
(d) (i) Is there history of alcohol misuse or alcohol dependency in the past 3 years?	☐	☐
(ii) Is there a history of illicit drug or substance use or dependency in the past 3 years? If YES to (i) or (ii) please give details in SECTION 7	☐	☐

SECTION 5 GENERAL

		YES	NO
(a)	Has the applicant CURRENTLY a significant disability of the spine or limbs which is likely to impair control of the vehicle? If YES please give details in SECTION 7	☐	☐
(b)	Is there a history of bronchogenic or other malignant tumour with a significant liability to metastasise cerebrally?	☐	☐
	(i) If YES, please give dates and diagnosis and state whether there is current evidence of dissemination		
(c)	Is the applicant profoundly deaf?	☐	☐
(d)	Could this be overcome by any means to allow a telephone to be used in an emergency?	☐	☐

SECTION 6 CARDIAC

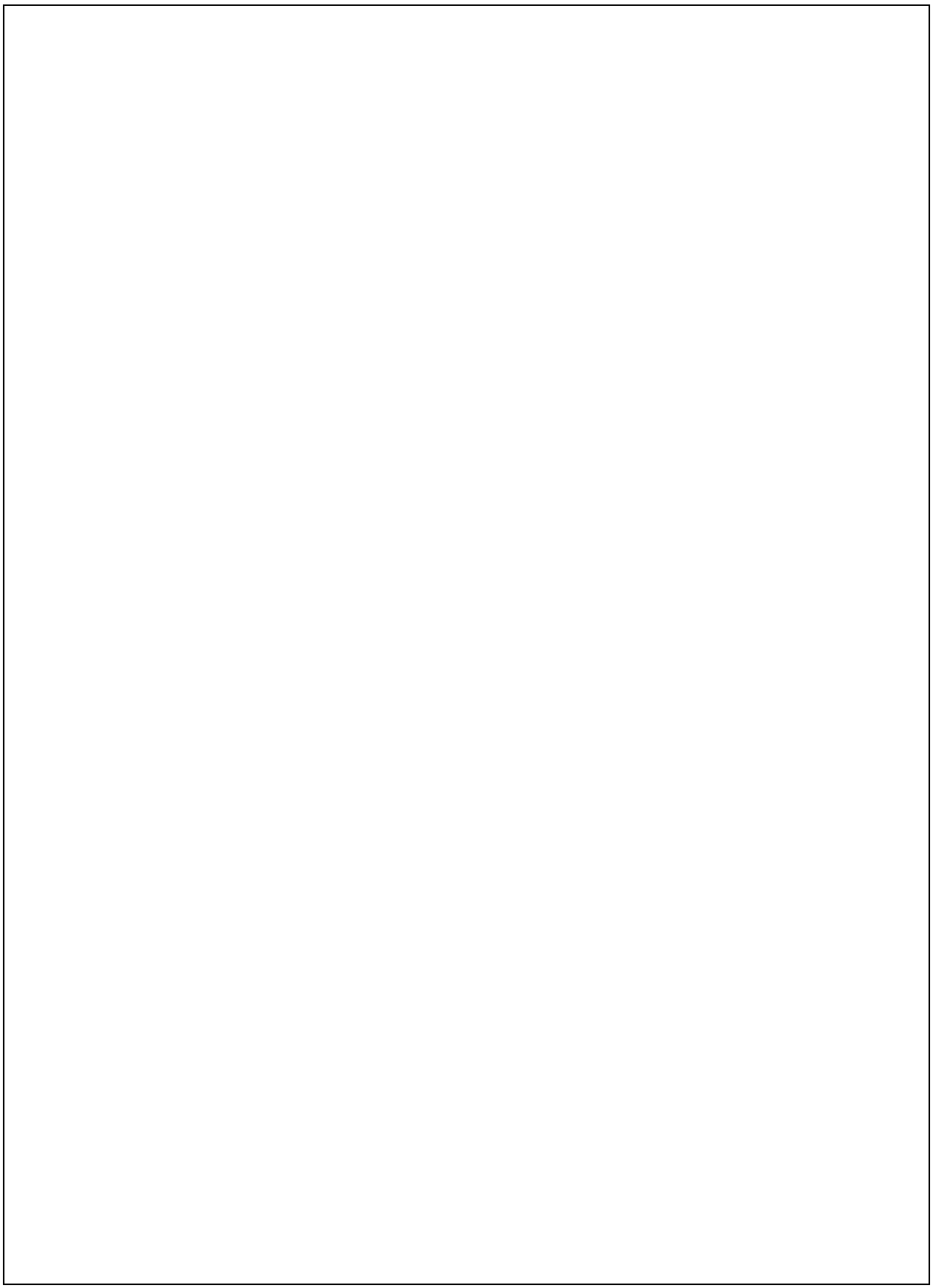
		YES	NO
A.	**CORONARY ARTERY DISEASE** Is there a history of: -		
(i)	Myocardial infarction? If YES, please give date(s)	☐	☐
(ii)	Coronary artery by-pass graft? If YES, please give date(s)	☐	☐
(iii)	Coronary Angioplasty? If YES please give date(s)	☐	☐
(iv)	Any other Coronary artery procedures? If YES please give details in SECTION 7	☐	☐
(v)	Has the applicant suffered from Angina?	☐	☐
(vi)	Is the applicant STILL suffering from Angina or only remains Angina free by the use of medication?	☐	☐
(vii)	Has the applicant suffered from Heart Failure?	☐	☐
(viii)	Is the applicant STILL suffering from Heart Failure or only remains controlled by medication?	☐	☐
(ix)	Has a resting ECG been undertaken? If YES please give date?	☐	☐
(x)	Does it show pathological Q waves?	☐	☐
(xi)	Does it show Left Bundle branch block?	☐	☐
(xii)	Has an exercise ECG been undertaken (or planned)? If YES please give date	☐	☐
(xiii)	Has an angiogram been undertaken? If YES please give date and give details in SECTION 7	☐	☐

			YES	NO
B		**CARDIAC ARRHYTHMIA**		
	(i)	Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years? If YES please give details in SECTION 7	☐	☐
	(ii)	Has the arrhythmia (or its medication) caused symptoms of sudden dizziness or impairment of consciousness or any symptom likely to distract attention during driving within the past 2 years?	☐	☐
	(iii)	Has Echocardiography been undertaken? If YES please give details in SECTION 7	☐	☐
	(iv)	Has an exercise test been undertaken? If YES please give details in SECTION 7	☐	☐
	(v)	Has a PACEMAKER been implanted?	☐	☐
	(vi)	If YES was it implanted to prevent Bradycardia?	☐	☐
	(vii)	Is the applicant now free of sudden and/or disabling symptoms?	☐	☐
	(viii)	Does the applicant attend a pacemaker clinic regularly?	☐	☐
	(ix)	Has a Cardiac defibrillator been implanted or antiventricular tachycardia device been fitted?	☐	☐
C		**OTHER VASCULAR DISORDERS**	**YES**	**NO**
	(i)	Is there a history of Aortic Aneurysm with a transverse diameter of 5cm or more (Thoracic or abdominal)	☐	☐
	(ii)	If YES, has the aneurysm been successfully repaired?	☐	☐
	(iii)	Is there symptomatic peripheral arterial disease?	☐	☐
	(iv)	Has there been dissection of the Aorta?	☐	☐
D		**BLOOD PRESSURE**	**YES**	**NO**
	(i)	Is there a history of hypertension with BP reading consistently greater than 180 systolic or 100 diastolic? If YES please supply most recent reading with dates.	☐	☐
	(ii)	If treated does the medication cause any side effects likely to affect safe driving?	☐	☐
E		**VALVULAR HEART DISEASE**	**YES**	**NO**
	(i)	Is there a history of valvular heart disease (with or without surgery?)	☐	☐
	(ii)	Is there any history of embolism?	☐	☐
	(iii)	Is there any history of arrhythmia – intermittent or persistent?	☐	☐
	(iv)	Is there any persistent dilatation or hypertrophy of either ventricle? If YES please give details in SECTION 7	☐	☐

			YES	NO
F	**CARDIOMYOPATHY**			
	(i)	Is there established cardiomyopathy?	☐	☐
	(ii)	Has there been a heart or heart/lung transplant? If YES please give details in SECTION 7	☐	☐
G	**CONGENITAL HEART DISORDERS**		**YES**	**NO**
	(i)	Is there a congenital heart disorder?	☐	☐
	(ii)	If YES, is it CURRENTLY regarded as minor?	☐	☐
	(iii)	Is the patient in the care of a Specialist clinic? If YES please give details in SECTION 7	☐	☐

SECTION 7 FURTHER DETAILS

Please provide any further information that is deemed necessary (use additional sheets if required)



SECTION 8 COMPLETING MEDICAL PRACTITONER'S DECLARATION

Name of Doctor *(please print)*

Name and Address of Practice
(Official Stamp is Required)

Part A
I hereby certify that by completing Part B of this medical certificate, **I have had regard all the medical Records of the applicant.**

Signed

Date

Part B
I hereby certify that **(Applicant Name)**_____

(Date Of Birth) _____ of **(Applicants Address)**_____

_____,

is fit to drive a Hackney Carriage/Private Hire Vehicle having regard to ALL the medical criteria for GROUP 2 ENTITLEMENT as detailed in the latest edition of the document "Medical Practitioners" At a Glance Guide to the Current Medical Standards of Fitness to Drive", issued by the Drivers Medical Group, DVLA, Swansea
(*please see note below*).*

Signed

Date

To The Medical Practitioner.
**When determining the fitness of a person to drive in respect of this certificate, you must have regard to the latest edition of the above mentioned DVLA document, which is frequently updated and amended. A copy of the latest edition is available from the DVLA, Swansea.*