MANCHESTER CITY COUNCIL

Updated 27 September 2019

Checked By:	Date:
Licence/Application Number	

Group II Medical Examination Report Form

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act 1976 to provide a Medical Examination Report that a person is physically fit to drive a Hackney Carriage or Private Hire Vehicle.

Before making your application for a private hire/hackney carriage driver licence:

Go online and read the 'medical rules for all drivers' at www.directgov.uk/motoring

Private hire and hackney carriage drivers are required to meet the **DVLA Group II medical standard**. If an applicant does not think that they will meet the medical or eyesight standard they should speak with their GP (Doctor) or optician before submitting an application or arranging a Group II Medical assessment appointment.

When is a Medical required?

- When submitting a new application for a private hire or hackney carriage driver licence
- When a driver reaches the age of 50 years, 55 years, 60 years and 65 years
- After 65 years – every year
- Some medical conditions will need an annual medical Certificate or an annual letter from a Doctor indicating that a current medical condition is under control and remains stable

Completion of this form:

This form must be completed by the applicants own Doctor or another Doctor who has access to the applicants full medical record at the time of the examination.

The form must be fully completed in block capitals using **black ink.** When attending the appointment applicants must take photo identification a passport or DVLA driver licence with them so that the Doctor can confirm the identity of the person attending medical.

The applicant must complete **Driver Declaration in front of the doctor** who is carrying out the examination.

GP (Doctor)

Before carrying out the assessment GP's must be fully aware of the current DVLA Group II medical standard https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals

GP's must ensure the identity of the individual (by completing 'Driver Identification on page 3) who has attended for the Medical Assessment and must write the full name and date of birth on the bottom of each sheet of the medical certificate.

All sections of the form must be completed including Section 10 – GP Declaration and whether the applicant meets or does not meet the Group 2 Medical requirements. The form must be signed and dated and include the Surgery stamp.

Individuals who are asymptomatic at the time of the examination should be advised that if in future they develop symptoms that could affect the safety of their driving that they must inform DVLA (where applicable) and or the taxi licensing unit by e-mailing taxi.licensing@manchester.gov.uk

Applicant Full Name: Date for Birth: DD/MM/YYYY

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If this form is not fully completed, we will return it to you and your application will be delayed.

Applicant Details:

First Name														
Middle Name														
Surname (Family Name)														

Address														
Town														
City														
Post Code														

Date of Birth DD/MM/YYYY Email address @

Contact telephone number

Examining Doctors Details to be completed by the doctor carrying out the examination

First Name														
Surname														

Address														
Post Code														

Phone number: _____ Email address _____

GMC registration number

Applicant Full Name: Date for Birth: DD/MM/YYYY

Driver Identification:

Documents seen:

Passport ☐

DVLA driver licence photocard ☐

Applicant Date of Birth: DD/MM/YYYY

Verified against patient records: Yes ☐

GP (Doctor): Signature:

Please write the applicants full name and date of birth at the bottom of each page.

Applicant Full Name: Date for Birth: DD/MM/YYYY

Vision Assessment - to be completed by an optician or optometrist.

If correction is needed to meet the eyesight standard for driving, all questions must be answered.

If correction is not needed, questions 5 and 6 can be ignored.

1. Please confirm (✓) the scale you are using to express the driver's visual acuities

☐ Snellen ☐ Snellen expressed as a decimal ☐ LogMAR

2. Please state the visual acuity of each eye (see INF4D). Snellen readings with a (+) or (-) are **not** acceptable. If 6/7.5, 6/60, standard is not met. The applicant may need further assessment by an optician.

Uncorrected		**Corrected**	
R	**L**	**L**	**R**

3. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye? (Corrective lenses may be worn to meet this standard. Yes ☐ No ☐	7. 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 formal visual filed testing is considered necessary, DVLA will commission this at a later date.
4. Were corrected lenses worn to meet the standard? Yes ☐ No ☐ If yes was this Glasses ☐ Contact Lenses ☐ Both ☐	8. Is there any diplopia? Yes ☐ No ☐ Is it controlled Yes ☐ No ☐ If yes please provide full details
5. If glasses (not contact lenses) are worn for driving is the corrective power greater than plus (+8) dioptres in any meridian of either lens? Yes ☐ No ☐	9. When questioned, does the applicant report symptoms of intolerance to glare and /or impaired contrast to sensitivity and/or impaired twilight vision that impairs their ability to driver? Yes ☐ No ☐
6. If a correction is worn for driving, is it well tolerated? Yes ☐ No ☐ If No – please provide details	10. Does the applicant have any other ophthalmic condition? Yes ☐ No ☐

If Yes to any questions 7-20 – provide full details here. (please use additional sheet if necessary)

Examining Doctor /Optician (print) Name:

Signature: Date: DD/MM/YYYY

GOC, HIPC or GMC Number									

Applicant Full Name: Date for Birth: DD/MM/YYYY

Where the answer is <u>No</u> please go to the next question/section throughout.

Section 1. NEUROLOGICAL DISORDERS

Please tick ✓ the appropriate box (es)	**Yes**	**No**
Is there any history of, or evidence of any neurological disorder?	☐	☐

If no go to section 2. If yes answer all questions below; Give details in Section 6 where you have answered 'Yes' and enclose relevant hospital notes.

1. Has the applicant had any form of seizure? ☐ ☐

(a) Has the applicant had more than one attack? ☐ ☐

(b) Date of first Attack DD/MM/YYYY Date of last attack DD/MM/YYYY

(c) Is the applicant currently on anti-epileptic medication? ☐ ☐

If 'Yes' please give details of current medication in **Section 8**

(d) If no longer treated, please give date when treatment ended? DD/MM/YYYY

(e) Has the applicant had a brain scan? ☐ ☐

(f) Has the applicant had an EEG? ☐ ☐

2. Stroke or TIA ☐ ☐

If yes please give date DD/MM/YYYY

Has there been a full recovery? ☐ ☐

Has a carotid ultrasound taken place? ☐ ☐

3. Sudden and disabling dizziness /vertigo within the past 1 year with liability recur. ☐ ☐

4. Subarachnoid Haemorrhage? ☐ ☐

5. Serious traumatic brain injury within the last 10 years? ☐ ☐

6. Any form of brain tumour? ☐ ☐

7. Other brain surgery or abnormality? ☐ ☐

8. Chronic Neurological Disorder? ☐ ☐

9. Parkinson's Disease? ☐ ☐

10. Is there any history of blackout or impaired consciousness within the past 5 years? ☐ ☐

11. Does the applicant suffer from narcolepsy ☐ ☐

Section 2. DIABETES MELLITUS

1.	Yes	No
Does the applicant have Diabetes Mellitus? (if no go to Section 3)	☐	☐
If yes please answer all of the following questions		
(a) Is the diabetes managed by insulin?	☐	☐
If yes please give date started on insulin DD/MM/YYYY		
(b) If treated with insulin is there evidence of at least 3 continuous months of blood glucose readings stored on a memory meter(s)?	☐	☐
If 'No please give details in Section 6 of the form		
(c) Are there other injectable treatments?	☐	☐
(d) Is there a Sulphonyl urea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents or diet?	☐	☐
(f) Diet Only?	☐	☐
If yes to any (a-e) fill in current medication in Section 8		

2. Are you satisfied that the applicant has provided evidence (last 3 months) that-		
(a) Blood sugar is tested at least twice every day?	☐	☐
(b) Blood sugar is tested at times relevant to *driving?	☐	☐
(*no more than 2 hours before the start of a journey and every 2 hours whist driving)		
Do you have confidence that the applicant?		
(c) Keeps fast-acting carbohydrate within easy reach whilst driving?	☐	☐
(d) Has a clear understanding of diabetes and the necessary precautions for safe driving	☐	☐

3. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐

4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person	☐	☐

5.		
(a) Is there any evidence of loss of visual field?	☐	☐
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?		
If Yes, to 4-5 above please give details in Section 6.		
6. Has there been any laser treatment or intravitreal treatment for retinopathy?	☐	☐
If yes please give date(s) of treatment DD/MM/YYYY DD/MM/YYYY DD/MM/YYYY		

Applicant Full Name: Date for Birth: DD/MM/YYYY

Section 3. CARDIAC

Section 3a Coronary Heart Disease

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

If **No** go to section 3b.

If **Yes** answer all questions below and give details in Section 6 of the form and enclose relevant hospital notes

1.	Has the applicant suffered from angina If yes please give date of last known attack DD/MM/YYYY	☐	☐
2.	Acute coronary syndrome, including myocardial infarction? If yes please give date DD/MM/YYYY	☐	☐
3.	Coronary angioplasty (PCI)? If yes give date of most recent intervention DD/MM/YYYY	☐	☐
4.	Coronary artery bypass graft surgery? If yes please give date DD/MM/YYYY	☐	☐

Section 3b Cardiac arrhythmia

	Yes	No
Is there a history or any evidence of cardia arrhythmia?	☐	☐

If **No** go to section 3c

If **Yes**, please answer all questions and give details in Section 6 and enclose relevant hospital notes.

1.	Has there been a significant disturbance of cardiac rhythm (ie. sinoatrial disease, significant atrioventricular conduction defect, and atrial flutter/fibrillation, narrow or broad complex tachycardia) in the last 5 years?	☐	☐
2.	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3.	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	☐	☐
4.	Has a pacemaker been fitted?	☐	☐
(a)	If yes please give date DD/MM/YYYY		
(b)	Is the patient free of symptoms that caused the device to be fitted?	☐	☐
(c)	Does the patient attend a pacemaker clinic regularly?	☐	☐

Section 3c Peripheral Arterial Disease	Yes	No
Is there a history or evidence of peripheral arterial disease? (Excluding Buerger's disease aortic aneurysm/dissection)	☐	☐

If **No** go to section 3d

If **Yes** answer all questions below and give details in section 6 of the form and enclose relevant hospital notes

1. Peripheral Arterial Disease (excluding Buerger's disease)	☐	☐
2. Does the patient have claudication?	☐	☐
If Yes, how long in minutes can the applicant walk at a brisk pace before being symptom-limited: mins		
3. Aortic aneurysm?	☐	☐
(a) Site of aneurysm? Thoracic ☐ Abdominal ☐	☐	☐
(b) Has it been repaired successfully?		
(c) Is the transverse diameter currently > 5.5cm If not please provide latest measurement and date obtained DD/MM/YYYY	☐	☐
4. Dissection of the aorta repaired successfully? 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 If **Yes** please provide relevant hospital notes	☐	☐

Section 3d Valvular/congenital heart disease	Yes	No
Is there a history or evidence of valvular/congenital heart disease?	☐	☐

If **No** go to section 3e

If **Yes** answer all questions below and give details in Section 6 of the form and enclose relevant hospital notes

1. Is there a history of congenital heart disease?	☐	☐
2. Is there a history of heart valve disease?	☐	☐
3. Is there a history of aortic stenosis? If **Yes** please provide relevant reports	☐	☐
4. Is there a history of embolism (not pulmonary embolism)?	☐	☐
5 Does the applicant currently have significant symptoms?	☐	☐
6 Has there been any progression since the last licence application? (where relevant)	☐	☐

Applicant Full Name: Date for Birth: DD/MM/YYYY

Section 3e Cardiac Other — Yes No

Is there a history or evidence of heart failure? ☐ ☐

If **No** go to section 3f

If **Yes** answer all questions below and give details in Section 6 of the form and enclose relevant hospital notes

1. Established cardiomyopathy? ☐ ☐
2. Has a left ventricular assist device (LVAD) been implanted? ☐ ☐
3. A heart or heart/lung transplant? ☐ ☐
4. Untreated atrial myxoma? ☐ ☐

Section 3f Cardiac Channelopathies — Yes No

Is there a history or evidence of either of the following conditions?

If **No** go to section 3g

If **Yes** answer all questions below and give details in section 6 of the form and enclose relevant hospital notes

1. Brugada syndrome? ☐ ☐
2. Long QT syndrome? ☐ ☐

If **Yes** to either, give details and enclose copies of relevant hospital notes

Section 3g Blood Pressure — Yes No

If resting blood pressure is 180 mm/HG systolic or more and or 100 Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 reading in the box provided

1. Please record todays **best resting** blood pressure reading ☐
2. Is the applicant on ant-hypertensive treatment? ☐ ☐

If Yes, please provide three previous readings with dates if available

Reading	**Date**					
	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? ☐ ☐

If Yes please provide details in Section 6 (including date of diagnosis and any treatment etc)

Applicant Full Name: Date for Birth: DD/MM/YYYY

Section 3h Cardiac Investigations	Yes	No
Have any cardiac investigations been undertaken or planned?	☐	☐
If **No** go to Section 4. If **Yes** answer questions 1-6		
1. Has a resting ECG been undertaken?	☐	☐
If yes does it show:		
(a) pathological Q waves?	☐	☐
(b) left bundle branch block	☐	☐
(c) right bundle branch block?	☐	☐
If Yes to a, b, or c please provide a copy of the relevant ECG report or comment at Section 6		
2. Has an exercise ECG been undertaken?	☐	☐
If yes please give date DD/MM/YYYY		
Provide details in Section 6 and relevant reports if available		
3. Has an echocardiogram been undertaken or planned?	☐	☐
(a) If yes please give date DD/MM/YYYY		
Provide details in Section 6 and relevant reports if available		
(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?		
Provide relevant reports		
4. Has a coronary angiogram been undertaken?	☐	☐
If yes please give date DD/MM/YYYY		
Provide details in Section 6 and relevant reports if available		
5. Has a 24 hour ECG tape been undertaken?	☐	☐
If yes please give date DD/MM/YYYY		
Provide details in Section 6 and relevant reports if available		
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?	☐	☐
If yes please give date DD/MM/YYYY		
Provide details in Section 6 and relevant reports if available		

Section 4. PSYCHIATRIC ILLNESS	Yes	No
Is there a history of psychiatric illness or drug/alcohol abuse within the last three years?	☐	☐
If **No** go to question 5. If **Yes** please answer all questions and provide full details in **Section 6,** Including dates, period of stability and, where appropriate, consumption and frequency of use.		
1. Significant psychiatric disorder within the past 6 months?	☐	☐
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression?	☐	☐
3. Dementia or cognitive impairment?	☐	☐
4. Persistent alcohol misuse in the past 12 months?	☐	☐

5. Alcohol dependency in the past 3 years? ☐ ☐

6. Persistent drug misuse in the past 12 months? ☐ ☐

7. Drug dependency in the past three years? ☐ ☐

Section 5. GENERAL Yes No

All of the following questions must be answered. If **Yes** to any, give full details in Section 6
And enclose copies of relevant hospital notes.

1. Is there any history of, or evidence of obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? ☐ ☐
If **yes** please give the diagnosis

(a) If obstructive Sleep Apnoea Syndrome please indicate the severity?

Mild (AHI<15) ☐ Severe (AHI > 29) ☐

Moderate (AHI 15-19) ☐ 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.

(b) Please answer all questions (i) to (vi) for sleep conditions:

(i) Date of diagnosis DD/MM/YY

(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

(vi) Date of last review DD/MM/YY

2. Is there currently any functional impairment that is likely to affect control of the vehicle? ☐ ☐

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? ☐ ☐

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? ☐ ☐

5. Is the applicant profoundly deaf? ☐ ☐

If yes, is the applicant able to communicate in the event of an emergency by speech or by using a device e.g. textphone?

6. Does the applicant have a history of liver disease of any origin? ☐ ☐
If yes please give details in Section 6

7. Is there a history of renal failure? ☐ ☐
If yes please give details in Section 6

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? ☐ ☐

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? ☐ ☐
If yes please provide details of medication in Section 6

10. Does the applicant have any other medical condition that could affect safe driving? ☐ ☐
If yes please provide details in Section 6

Section 6 FURTHER DETAILS

Please provide further details and forward copies of relevant hospital notes. Please do not send any notes that do not relate to 'Fitness to Drive'

Applicant Full Name: Date for Birth: DD/MM/YYYY

Section 7 CONSULTANT DETAILS

Details of types of specialist(s) and or consultants including address:

Consultant in
Name
Address
Date of last appointment DD MM YY

Consultant in
Name
Address
Date of last appointment DD MM YY

Consultant in
Name
Address
Date of last appointment DD MM YY

Section 8 MEDICATION

Medication	**Dosage**	**Medication**	**Dosage**
Reason for taking		**Reason for Taking**	
Medication	**Dosage**	**Medication**	**Dosage**
Reason for taking		**Reason for Taking**	

Section 9 ADDITIONAL INFORMATION

Applicants Weight	
Height	
Details of smoking habits – if any	
Number of alcohol units taken each week	

Section 10 – DECLARATIONS

Applicant – consent and declaration

This declaration must be completed by the applicant in front of the GP (Doctor) who is carrying out the medical examination and must not be altered in any way.

I understand that Manchester City Council may in certain circumstances, as part of its assessment of my fitness to drive a hackney carriage or private hire vehicle, require additional information about my medical fitness.

I declare that I have checked the details I have given on this Group II Medical Assessment Application Form, and that to the best of my knowledge and belief they are correct.

I declare that I have told my doctor about any medical symptoms which may affect my driving.

I authorise my doctor(s) and specialist(s) to release reports/additional information to Manchester City Council about my medical condition if necessary ie where an application/review needs to be determined at a hearing (relating to medical 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 they are correct.

I authorise Manchester City Council to release, where applicable, medical information to my doctor(s) and/or specialist(s) about the outcome of any hearing relating to my medical fitness to drive a hackney carriage or private hire vehicle.

I understand that The Council will never under any circumstances release information that is not relevant to fitness to drive, nor would the Council expect to receive this from your doctor(s).

Name

Signature **Date of Assessment:** DD/MM/YYYY

General Practitioner (Doctor) Declaration

I CERTIFY THAT: I am the named applicant's General Practitioner / General practitioner with full access to the applicants NHS records at the time of the examination
I CERTIFY THAT: I have reviewed all the applicant's medical history and have today examined the named applicant, and I consider that the applicant : **Has MET** ☐ OR **Has NOT MET** ☐ The Group II Standards of medical fitness, as applied by the DVLA to the licensing of lorry and bus drivers, which is required for licensed hackney carriage and private hire drivers.
I declare that the answers to all questions are true to the best of my knowledge and belief. I understand that it is an offence for the person completing this form to make a false statement or omit relevant details
GP Full Name
Signature **Date:** DD/MM/YYYY

Surgery Stamp

Next Medical Assessment: Medicals are required at age 50 then every 5 years until the age of 65 when an annual medical is required	
Some medical conditions may need additional medicals. If you think this is necessary please indicate below:	
Next medical assessment should be in	MM/YYYY

Applicant Full Name: Date for Birth: DD/MM/YYYY