Licensing Unit

MEDICAL CERTIFICATE
TO CERTIFY THAT AN APPLICANT FOR A HACKNEY CARRIAGE / PRIVATE HIRE DRIVER'S LICENCE IS FIT TO DRIVE THE PUBLIC

Note to Applicant

THIS MEDICAL MAY ONLY BE COMPLETED BY YOUR OWN GENERAL PRACTITIONER WITH WHOM YOU ARE REGISTERED, OR ANY OTHER GP WITHIN THE SAME PRACTICE WHO HAS FULL ACCESS TO YOUR RECORDS.

THE COVID 19 PANDEMIC HAS LIMITED THE CAPACITY OF SOME GP SURGERIES TO PROVIDE MEDICALS FOR APPLICANTS OF HACKNEY CARRIAGE/PRIVATE HIRE DRIVER'S LICENCES. IT IS ONLY IN THESE EXCEPTIONAL CIRCUMSTANCES THAT THE MEDICAL CERTIFICATE MAY BE COMPLETED BY A MEDICAL PRACTIONER WHO HAS FULL ACCESS TO YOUR SUMMARY OF MEDICAL RECORDS.

IT IS ONLY IN THESE EXCEPTIONAL CIRCUMSTANCES THAT MEDICAL CERTIFICATES COMPLETED BY A MEDICAL PRACTITIONER WILL BE ACCEPTED AND WILL ONLY ALLOW A DRIVER TO BE CONSIDERED FOR A 1 YEAR LICENCE.

ASSESSMENTS MUST NOT TAKE PLACE MORE THAN ONE CALENDAR MONTH BEFORE A LICENCE IS GRANTED OR RENEWED.

YOU ARE RESPONSIBLE FOR ANY FEES CHARGED BY YOUR DOCTOR/MEDICAL PRACTITIONER.

Note to Doctor

YOU SHOULD BE AWARE THAT **"MEDICAL ASPECTS OF FITNESS TO DRIVE"** PUBLISHED BY THE MEDICAL COMMISSION ON ACCIDENT PREVENTION IN 1995 RECOMMENDED THAT THE **GROUP 2 MEDICAL STANDARDS APPLIED BY DVLA IN RELATION TO BUS AND LORRY DRIVERS, SHOULD ALSO BE APPLIED BY LOCAL AUTHORITIES TO TAXI DRIVERS.**

DVLA INFORMATION LEAFLET INF4D MAY BE USED AS A REFERENCE DOCUMENT AND CAN BE VIEWED ONLINE AT HTTP://WWW.DVLA.GOV.UK/FORMS/PDF/INF4D.PDF

SECTION 1 – THE APPLICANT

Name of Applicant	

Date of Birth	
Home Address	
Post Code	
Telephone Number	
Email Address	
Applicant's consent & declaration	I authorise my General Practitioner(s) to provide information requested on this form relevant to my fitness to drive a licenced hackney carriage or private hire vehicle to Burnley Borough Council in order to assess my fitness to hold a hackney carriage or private hire driver's licence. I declare that to the best of my knowledge and belief all information given by me to my GP or Doctor in connection with this examination is true.
Date:	***Signed:***

GP Surgery Applicant Registered With

Name of Doctor	
Name of Surgery	
Address	
Post Code	
Telephone Number	

Examining Doctor Details (to be completed by the doctor carrying out examination)

First Name	
Surname	
Address	
Post Code	
Phone Number	
Email Address	
GMC Registration Number	
GP (Doctor) Signature	

Driver Identification

Documents seen (please tick):

Passport ☐

DVLA driver licence photo card ☐

Applicants Date of Birth: DD/MM/YYYY

Verified against patient records: ☐

Medical Examination Report
Part 2 – The Patient

weight (kg/ st)		
height (cms/ ft)		
Please give details of smoking habits, if any		
Please give number of alcohol units taken each week		
Is the urine sample taken, positive for Glucose?	**YES ☐**	**NO ☐**
Is the applicant currently seeing a specialist or consultant ?	**YES ☐**	**NO ☐**
Current medication including exact dosage and reason for each treatment	**Continue on Page 8 if necessary**	
VISION		
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. **Snellen readings with a 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.**	**Uncorrected** **R =** **L=**	**Corrected** **R=** **L=**
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 ☐**
4. Were corrective lenses worn to meet this standard? **If YES, glasses ☐ contact lenses ☐ both together ☐**	**YES ☐**	**NO ☐**

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** ☐
6. If correction is worn for driving, is it well tolerated? **If NO, please give full details in the box provided** **If you answer yes to any of the following give details in the box provided.**	**YES** ☐ **(details)**	**NO** ☐ **(details)**
7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? **If formal visual field testing is considered necessary, DVLA will commission this at a later date**	**YES** ☐	**NO** ☐
8. Is there diplopia?	**YES** ☐	**NO** ☐
a) If YES, is it controlled? **If YES, please give full details in the box provided**	**YES** ☐ **(details)**	
9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision?	**YES** ☐	**NO** ☐
10. Does the applicant have any other ophthalmic condition? **If YES, please give full details in the box provided**	**YES** ☐ **(details)**	**NO** ☐

NERVOUS SYSTEM		
Has the applicant had any form of epileptic attack?	**YES** ☐	**NO** ☐
(a) If Yes, please give date of last attack		
(b) If treated, please give date when treatment ceased		
Is there a history of blackout or impaired consciousness within the last 5 years?	**YES** ☐	**NO** ☐
Does the applicant suffer from narcolepsy / cataplexy?	**YES** ☐	**NO** ☐
Is there a history of, or evidence of any of the conditions below? • **Stroke/ TIA (*please delete as appropriate)*** • **Sudden and disabling dizziness/vertigo within the last 1**	**YES** ☐ **If yes please give details at the end of this report**	**NO** ☐

year with a liability to recur • Subarachnoid haemorrhage • Serious head injury within the last 10 years • Brain tumour, either benign or malignant, primary or secondary • Other brain surgery • Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis • Dementia or cognitive impairment		
DIABETES MELLITUS		
Does the applicant have diabetes mellitus?	YES ☐ If yes, continue below	NO ☐ If no, skip the remainder of this section.
Is the diabetes managed by:- (a) Insulin?	YES ☐ If YES, please give date started on insulin	NO ☐
(b) Oral hypoglycaemic agents and diet?	YES ☐	NO ☐
(c) Diet only?	YES ☐	NO ☐
Does the patient test blood glucose at least twice every day?	YES ☐	NO ☐
Is there evidence of loss of visual field?	YES ☐	NO ☐
Is there evidence of severe peripheral neuropathy, sufficient to impair limb function for safe driving?	YES ☐	NO ☐
Is there evidence of diminished/absent awareness of hypoglycaemia?	YES ☐	NO ☐
Has there been laser treatment for retinopathy?	YES ☐	NO ☐
Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party?	YES ☐	NO ☐

PSYCHIATRIC ILLNESS		
Is there a history of, or evidence of any of the conditions listed below ? • Significant psychiatric disorder within the past 6 months • A psychotic illness within the past 3 years including psychotic depression • Persistent alcohol misuse in the past 12 months • Alcohol dependency in the past 3 years • Persistent drug misuse in the past 12 months • Drug dependency in the past 3 years	YES ☐ If yes please give details at the end of this report	NO ☐ If no, skip the remainder of this section.

CARDIAC		
Is there a history of, or evidence of, coronary artery disease?	**YES ☐** **If yes please give details below and at the end of this report**	**NO ☐** **If no, skip the remainder of this section.**
Myocardial Infarction?	**YES ☐**	**NO ☐**
Coronary artery by-pass graft?	**YES ☐**	**NO ☐**
Coronary Angioplasty (with or without stent)?	**YES ☐**	**NO ☐**
Has the applicant suffered from Angina?	**YES ☐**	**NO ☐**
Is there a history of, or evidence of, cardiac arrhythmia?	**YES ☐**	**NO ☐**
Is there any history or evidence of PRIPHERAL ARTERIAL DISEASE	**YES ☐**	**NO ☐**
Is there any history or evidence of AORTIC ANEURYSM	**YES ☐**	**NO ☐**
Is there any history or evidence of DISSECTION OF THE AORTA	**YES ☐**	**NO ☐**
Is there any history or evidence of Valvular or congenital heart disease?	**YES ☐**	**NO ☐**
Does the applicant have a history of ANY of the following conditions: • **a history of, or evidence of heart failure?** • **established cardiomyopathy** • **a heart or heart/lung transplant?**	**YES ☐**	**NO ☐**

CARDIAC INVESTIGATIONS		
Has a resting ECG been undertaken?	**YES ☐** **If yes, continue below**	**NO ☐** **If no, skip the remainder of this section.**
If YES, does it show pathological Q waves?	**YES ☐**	**NO ☐**
If YES, does it show left bundle branch block?	**YES ☐**	**NO ☐**
Has an exercise ECG been undertaken (or planned)?	**YES ☐**	**NO ☐**
Has an echocardiogram been undertaken (or planned)?	**YES ☐**	**NO ☐**
Has a coronary angiogram been undertaken (or planned)?	**YES ☐**	**NO ☐**
Has a 24 hour ECG tape been undertaken	**YES ☐**	**NO ☐**

(or planned)?		
Has a myocardial perfusion imaging scan been undertaken (or planned)?	**YES** ☐	**NO** ☐
BLOOD PRESSURE		
Is today's resting systolic pressure 180mm Hg or greater?	**YES** ☐	**NO** ☐
Is today's resting diastolic pressure 100mm Hg or greater?	**YES** ☐	**NO** ☐
Is the applicant on anti-hypertensive treatment?	**YES** ☐	**NO** ☐
Please give todays BP reading		
GENERAL HEALTH		
Is there currently a disability of the spine or limbs, likely to impair control of the vehicle?	**YES** ☐	**NO** ☐
Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?	**YES** ☐	**NO** ☐
Is the applicant profoundly deaf?	**YES** ☐	**NO** ☐
If YES, is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/ text phone?	**YES** ☐	**NO** ☐
Is there a history of either renal or hepatic failure?	**YES** ☐	**NO** ☐
Does the applicant have sleep apnoea syndrome	**YES** ☐	**NO** ☐
If YES, has it been controlled successfully?	**YES** ☐	**NO** ☐
Is there any other Medical Condition, causing excessive daytime sleepiness	**YES** ☐ **If YES, please give full details at the end of this report.**	**NO** ☐

Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	**YES** ☐	**NO** ☐
Does any medication currently taken cause the applicant side effects which impair his/ her safe driving?	**YES** ☐	**NO** ☐
Is the applicant sufficiently active for the performance of his/her duties?	**YES** ☐	**NO** ☐

ADDITIONAL INFORMATION

To:

The Principal Licensing Officer, Licensing Unit, Burnley Borough Council, Contact Burnley, 9 Parker Lane, Burnley, BB11 2BY.

General Practitioner (Doctor) Declaration:

I certify that:

I have this day examined the above named person and have completed the above medical certificate.

I am the named applicant's General Practitioner / General practitioner with full access to the applicant's NHS records/summary of medical records at the time of the examination.

I have reviewed the applicant's medical history and have today examined the named applicant, and I consider the applicant:

Has MET ☐

Has NOT MET ☐

Group II Standards of medical fitness, as applied by the DVLA to the licensing of lorry and bus drivers, which is required for licenced 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 (Doctor) Full Name:

Signature: **Date:**

NOTE:

THIS SECTION SHOULD ONLY TO BE COMPLETED IF THIS MEDICAL CERTIFICATE HAS BEEN COMPLETED BY YOUR OWN GENERAL PRACTITIONER WITH WHOM YOU ARE REGISTERED, OR ANY OTHER GP WITHIN THE SAME PRACTICE WHO HAS FULL ACCESS TO YOUR RECORDS.

I CONSIDER THE APPLICANT SHOULD BE SUBJECT TO A FURTHER MEDICAL EXAMINATION IN: (Please tick)

3 years ☐ **(Applicable only to applicants when the medical form has been completed by applicant's own General Practitioner with whom he/she is registered, or any other GP within the same practice)**

1 year ☐

Other ☐ **(Not longer than 3 years) Please specify…….years**

NOTE.

All drivers who attain 65 years of age are required to undergo a medical examination annually.

Signature of Qualified & Registered Medical Practitioner

GMC Registration Number:

Date: SURGERY STAMP:

LICENSING UNIT ONLY – PLEASE DO NOT WRITE IN THE SPACE BELOW