MEDICAL EXAMINATION REPORT FOR HACKNEY CARRIAGE AND PRIVATE HIRE DRIVERS

When completed, please return this form with your application to:

CHORLEY COUNCIL
REGULATORY SERVICES TEAM
PUBLIC PROTECTION, STREETSCENE AND COMMUNITY DIRECTORATE
PO Box 13
Chorley
PR7 1AR

GROUP II MEDICAL EXAMINATION REPORT FORM

INFORMATION NOTES

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act, 1976, to provide a Medical Examination Report to the effect that you are physically fit to hold a Hackney Carriage / Private Hire Driver Licence and is for the confidential use of the Licensing Authority.

This form is to be completed by the applicant's own General Practitioner (GP) or another GP that can confirm they have had full access to the applicant's medical records.

You are required to complete a further Group II Medical Report Form for every Driving Licence renewal (every 3 years) until the age of 65. From the age of 65, a Group II Medical Report Form is required annually.

Any fees charged are payable by the applicant.

• PLEASE USE THIS FORM TO RECORD MEDICAL EXAMINATION DETAILS
• PLEASE COMPLETE IN BLOCK CAPITAL LETTERS IN BLACK INK

Licensing Officers are not permitted to complete or amend forms on behalf of applicants for legal reasons.

NOTE:
Any existing licensed private hire/hackney carriage driver must immediately inform the Council in writing of any deterioration in health or of any injury that would affect his/her ability to drive. (This is in addition to the requirement of Section 94 of the Road Traffic Act 1988 requiring any driver to notify the Secretary of State of any relevant disability)

GUIDANCE NOTES

What you have to do:

1. **Before** consulting your GP you may find it helpful to consult the DVLAs "At a Glance" booklet. This is available for download at the 'medical rules for all drivers' Section of http://www.direct.gov.uk/en/Motoring/index.htm

2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your GP/Optician **before** you arrange for this medical form to be completed as your GP will normally charge you for completing it. In the event of your application being refused, the fee you pay your GP is **not** refundable. Chorley Council has no responsibility for medical fees.

3. Fill in Section 8 of this report in the presence of the GP carrying out the examination.

4. Application forms must be submitted together with the Group II Medical Report Form otherwise there may be delays in processing your application.

What the GP has to do:

1. Please arrange for the patient to be seen and examined having access and regard for their medical records.

2. Please complete Sections 1-7 and 9 of this report. Please ensure the applicant completes Section 8 in your presence. You may find it helpful to consult the DVLAs website for up to date assessment of fitness to drive: https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals

3. Applicants who may be asymptomatic at the time of the examination are to be advised that, if in future they develop symptoms of a condition which could affect safe driving and they hold either a Hackney Carriage and/ or Private Hire driver licence they must immediately inform the Public Protection (Licensing) Team at Chorley Council . Please record any advice given at Section 7.

4. Please ensure that you have completed all Sections within this form. If this report does not bring out important clinical details which may affect the applicant's fitness to drive, please give details in Section 7.

MEDICAL EXAMINATION REPORT

Applicant's Details

To be completed in the presence of the
Medical Practitioner carrying out the examination

Your Details

Your full name		Date of Birth	DD	MM YY
Your address		Home tel. no.		
		Work/Day no.		
Email address				

About your GP/Group Practice

GP/Group name	
Address	
Telephone	
Email address	
Fax number	

To be completed by the Doctor (please use black ink)

Please give patient's 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 analysis positive for Glucose? No ☐ Yes ☐ (please tick appropriate box)

Details of specialist(s)/ consultants, including address	1	2	3
Speciality			

Date last seen			

Current medication including exact dosage and reason for each treatment	

Date when first licensed to drive a taxi/PH vehicle		And/or lorry		And/or bus	

1 Vision

Please tick the appropriate boxes	**YES**	**NO**
1. Does the applicant FAIL to achieve a visual acuity of at least 6/7.5 (in the better eye) 6/60 (in the worse eye) using corrective lenses if necessary. (as measured with the full size 6m Snellen chart).	☐	☐
2. Is the applicant monocular, ie. (visual acuity less than 3/60 in one eye).	☐	☐

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart.
Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected				**Corrected (if applicable)**			
Right		Left		Right		Left	

If corrective lenses are worn to achieve this please confirm the following:

Glasses		**Contact Lenses**		**Both together**	

4. Is there a defect in his/her binocular field of vision (central and/or peripheral)?	☐	☐
5. Is there diplopia? (Controlled or uncontrolled)?	☐	☐
6. Does the applicant have any other ophthalmic condition?	☐	☐

Where the visual acuity requirements are not met or If **YES** to 4, 5 or 6, please give details in Section 7 and enclose any relevant visual field charts or hospital letters.

2 Nervous System

Please tick the appropriate boxes	**YES**	**NO**
1. Has the applicant had any form of epileptic attack?	☐	☐

	DD	MM	YY
a) If Yes, please give date of last attack			
b) If treated, please give date when treatment ceased			

c) Is the applicant currently on anti-epileptic medication? If **YES,** please complete current medication on the appropriate section of the front of this form	☐	☐
2. Is there a history of blackout or impaired consciousness within the last 5 years?	☐	☐

If **YES,** please give date(s) and details in **Section 7**

3. Does the applicant suffer from narcolepsy/cataplexy? ☐ ☐
If **YES,** please give details in **Section 7**

4. Is there a history of, or evidence of any of the conditions listed at a-h below? ☐ ☐
If NO, go to **Section 3.**
If YES, please tick the relevant box(es) and give dates and full details at **Section 7.**
a) Stroke/TIA *please delete as appropriate* ☐

b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur ☐

c) Subarachnoid haemorrhage ☐

d) Serious head injury within the last 10 years ☐

e) Brain tumour, either benign or malignant, primary or secondary ☐

f) Other brain surgery ☐

g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis ☐

h) Dementia or cognitive impairment ☐

3 Diabetes Mellitus

Please tick the appropriate boxes	**YES**	**NO**
1. Does the applicant have diabetes mellitus? If **NO,** please proceed to **Section 4** If **YES,** please answer the following questions.	☐	☐

Please tick the appropriate boxes	**YES**	**NO**
2. Is the diabetes managed by:- a) Insulin?	☐	☐
If **YES**, please give date started on insulin DD MM YY		
b) Oral hypoglycaemic agents and diet? If YES, please complete current medication on the appropriate section on the front of this form	☐	☐
c) Diet only?	☐	☐
3. Does the applicant test blood glucose at least twice every day?	☐	☐
4. Is there evidence of:- a) Loss of visual field?	☐	☐
b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
c) Diminished/Absent awareness of hypoglycaemia?	☐	☐
5. Has there been laser treatment for retinopathy?	☐	☐
If **YES,** please give date(s) of treatment		
6. Is there a history of hypoglycaemia during **waking** hours in the last 12 months requiring assistance from a third party?	☐	☐

If **YES** to any of 4-6 above, please give details in **Section 7**

4 Psychiatric Illness

Please tick the appropriate boxes	**YES**	**NO**
Is there a history of, or evidence of any of the conditions listed at 1-6 below?	☐	☐

If NO, please go to **Section 3**
If YES, please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7.**
NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1.

1. Significant psychiatric disorder within the past 6 months ☐

2. A psychotic illness within the past 3 years, including psychotic depression ☐

3. Persistent alcohol misuse in the past 12 months ☐

4. Alcohol dependency in the past 3 years ☐

5. Persistent drug misuse in the past 12 months ☐

6. Drug dependency in the past 3 years ☐

NB. Please enclose relevant hospital notes with reference to this condition

5 Cardiac

Please follow the instructions in all sections (5A-5G) giving details as required in Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed on page 5.

5A Coronary Artery Disease

Please tick the appropriate boxes	**YES**	**NO**
Is there a history of, or evidence of, coronary artery disease?	☐	☐

If NO, proceed to **Section 5B**
If YES please answer all questions below and give details at **Section 7** of the form.

1. Acute Coronary Syndrome including Myocardial Infarction? ☐ ☐

If **YES**, please give date(s) | D D | M M | Y Y |

2. Coronary artery by-pass graft? ☐ ☐

If **YES**, please give date(s) | D D | M M | Y Y |

3. Coronary Angioplasty (P.C.I) ☐ ☐

If **YES**, please give date(s) | D D | M M | Y Y |

4. Has the applicant suffered from Angina? ☐ ☐

If **YES**, please give the date of the last attack | D D | M M | Y Y |

Please proceed to next Section 5B

5B Cardiac Arrhythmia

Please tick the appropriate boxes	**YES**	**NO**
Is there a history of, or evidence of, cardiac arrhythmia? **If NO,** proceed to **Section 5C** **If YES** please answer all questions below and give details at **Section 7** of the form.	☐	☐
1. Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years?	☐	☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3. Has a cardiac defibrillator device (I.C.D) been implanted	☐	☐
4. Has a pacemaker been implanted?	☐	☐
If **YES:-**		
a) Has the pacemaker been implanted for at least 6 weeks?	☐	☐
b) Since implantation of the pacemaker, is the applicant now symptom free as a result?	☐	☐
c) Does the applicant attend a pacemaker clinic regularly?	☐	☐

Please proceed to next Section 5C

5C Peripheral Arterial Disease

Please tick the appropriate boxes	**YES**	**NO**
1. Is there a history or evidence of ANY of the below: If **YES** please **tick** ALL relevant boxes below, and give details at **Section 7** of the form.	☐	☐
PERIPHERAL ARTERIAL DISEASE	☐	☐
AORTIC ANEURYSM		
IF YES:		
a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐		
b) Has it been repaired successfully?	☐	☐
c) Is the transverse diameter more than 5cms?	☐	☐

Please tick the appropriate boxes	**YES**	**NO**
DISSECTION OF THE AORTA	☐	☐
IF YES:		
d) Has it been repaired successfully?	☐	☐

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

Please tick the appropriate boxes	**YES**	**NO**
Is there a history of, or evidence of, valvular/congenital heart disease? **If NO,** proceed to **Section 5E** **If YES** please answer all questions below and give details at **Section 7** of the form.	☐	☐
1. Is there a history of congenital heart disorder?	☐	☐
2. Is there a history of heart valve disease?	☐	☐
3. Is there any history of embolism? (**not** pulmonary embolism)	☐	☐
4. Does the applicant currently have significant symptoms?	☐	☐
5. Has there been any progression since the last licence application? (if relevant)	☐	☐

Please proceed to next Section 5E

5E Cardiomyopathy

Please tick the appropriate boxes	**YES**	**NO**
Does the applicant have a history of ANY of the following conditions:	☐	☐
a) a history of, or evidence of heart failure?		
b) established cardiomyopathy?		
c) a heart or heart/lung transplant?		

If YES to any part of the above, please give full details in Section 7 of the form. If NO proceed to next Section 5F.

5F Cardiac Investigations

Please tick the appropriate boxes	**YES**	**NO**
This section must be completed for all applicants.		
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?	☐	☐
2. Has an exercise ECG been undertaken (or planned)?	☐	☐
If **YES**, please give date and give details in **Section 7** D D M M Y Y		
Sight/copy of the exercise test result/report (if done in the last 3 years) would be helpful		

Please tick the appropriate boxes	**YES**	**NO**
3. Has an echocardiogram been undertaken (or planned)?	☐	☐
a) If **YES** please give date and give details in Section 7 D D M M Y Y		
b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%?	☐	☐
Sight/copy of the echocardiogram result/report would be helpful		
4. Has a coronary angiogram been undertaken (or planned)?	☐	☐
If **YES**, please give date and give details in **Section 7** D D M M Y Y		
Sight/copy of the angiogram result/report would be helpful		
5. Has a 24 hour ECG tape been undertaken (or planned)?	☐	☐
If **YES**, please give date and give details in **Section 7** D D M M Y Y		
Sight/copy of the 24 hour tape result/report would be helpful		
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?	☐	☐
If **YES**, please give date and give details in **Section 7** D D M M Y Y		
Sight/copy of the scan result/report would be helpful		

Please proceed to Section 5G

5G Blood Pressure

Please tick the appropriate boxes **YES** **NO**

This section must be completed for all applicants.

1. Is today's resting systolic pressure 180mm Hg or greater? ☐ ☐

2. Is today's resting diastolic pressure 100mm Hg or greater? ☐ ☐

3. Is the applicant on anti-hypertensive treatment? ☐ ☐

If YES, to any of the above, please supply today's reading and three previous readings and dates.

6 General

Please tick the appropriate boxes **YES** **NO**

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 7.

1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle? ☐ ☐

2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? ☐ ☐

If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination.

Please tick the appropriate boxes **YES** **NO**

3. Is the applicant profoundly deaf? ☐ ☐

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? ☐ ☐

4. Is there a history of either renal or hepatic failure? ☐ ☐

5. Does the applicant have sleep apnoea syndrome? ☐ ☐

If **YES,** please supply details

a) Date of diagnosis

DD	MM	YY

b) Is it controlled successfully? ☐ ☐

c) If **YES**, please state treatment

d) Please state period of control

6. Is there any other **Medical Condition**, causing excessive daytime sleepiness? ☐ ☐
If **YES,** please supply details

a) Diagnosis

b) Date of diagnosis DD MM YY

c) Is it controlled successfully? ☐ ☐

d) If **YES**, please state treatment

e) Please state period of control

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

8. Does any medication currently taken cause the applicant side effects that affect safe driving? ☐ ☐
If **YES,** please supply details of medication

9. Does the applicant have any other medical condition that could affect safe driving? ☐ ☐
If **YES,** please supply details

7 Please forward copies of relevant hospital notes **only**.
PLEASE DO NOT send any notes not related to fitness to drive.

8 Applicant's consent and declaration

Consent and Declaration

This section MUST be completed and must NOT be altered in any way.
Please read the following important information carefully then sign the statements below.

Important information about Consent

I accept that as part of the investigation into my fitness to drive, Chorley Council, may require me to undergo further medical examination or some form of practical assessment. In these circumstances, those personnel involved will require my background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, specialist consultants, orthoptists at eye clinics or paramedical staff at a driving assessment centre.

Only information relevant to the assessment of my fitness to drive will be released. In addition, where the circumstances of my case appear exceptional, the relevant medical information may need to be further considered, where such further examination / consideration attracts a cost this will be met by me the applicant, (you will be advised of any further costs as appropriate to determine your application) and where matters of a medical nature exist the application may then be determined by the Councils Licensing Committee. (The HC/PH Driver licensing process is managed to strict principles of confidentiality, where applications are to be determined by the Councils Licensing Sub-Committee such meetings are held to the exclusion of the press and public).

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to Chorley Councils medical adviser.

I authorise Chorley Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to hold a HC/PH Drivers Licence, to doctors, paramedical, DVLA and to inform my doctor(s) of the outcome of the case where appropriate.

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.

During the period of application and any period when holding a private hire/hackney carriage driver licence, I will immediately inform Chorley Council in writing of any deterioration in health or of any injury or condition that would affect my ability to drive. (This is in addition to the requirement of Section 94 of the Road Traffic Act 1988 requiring any driver to notify the Secretary of State of any relevant disability.

"I understand that it is a criminal offence if I make a false declaration to obtain a private hire / hackney carriage driving licence and can lead to prosecution."

Signature		**Date**	

Medical Practitioner Details

To be completed by Doctor carrying out the examination

9 Doctor's details

Name	
Address	
Email address	
Fax number	

Surgery Stamp

I confirm that: _____ is registered with this Doctors Practice and I have checked and have had access to their medical history.

Signature of Medical Practitioner		**Date**	
Print Name of Medical Practitioner		**GP Reg Number**	