



St. Helens  
Council

## MEDICAL ASSESSMENT

ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A  
HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

### Notes for the Applicant

This medical assessment must be carried out by a General Practitioner in the medical practice to which you are registered or by a GP or Doctor who has access to your medical records which must be reviewed prior to completion of this assessment.

The vision assessment must be completed by a doctor or optician/optometrist. Some doctors will be able to fill in both vision and medical assessment section of the report. If your doctor is unable to fully answer all of the questions on the vision assessment you must have it completed by an optician/optometrist.

**IMPORTANT: ASSESSMENTS MUST NOT TAKE PLACE MORE THAN TWO CALENDAR MONTHS BEFORE THE DATE A LICENCE IS GRANTED OR RENEWED.**

### Applicant's Details: (to be completed in the presence of the GP or Doctor carrying out the examination)

Full name: ..... Date of Birth: ..... Age: .....

Address:

Post Code:

Contact telephone number:

Email:

### Privacy Policy

Here at St. Helens Council we take your privacy seriously. We will only use your personal information to administer your application and provide the products and services you have requested from us.

From time to time we may need to contact you with details of the service or information we require from you and we will do this using the contact information you provided on your application form. This can either be by post, email, telephone or text message.

The Council has a duty to protect the public and we implement a number of security measures to maintain the safety of your personal information. Please be aware however that the information you provide on this application may be shared with other public bodies where required, such as Council Departments and Government Services, which may be used for the prevention of fraud or other serious offences.

If you require a copy of the data we hold or believe it to be inaccurate please contact the Council's Data Protection Officer by email on [dataprotection@sthelens.gov.uk](mailto:dataprotection@sthelens.gov.uk).

Any further information held by the Council about individuals will be held securely and in compliance with the law. Information will not be held for longer than required and will be disposed of securely. Further information regarding retention periods is available on the Council's website at <https://www.sthelens.gov.uk/Licensing>.

### Applicant's consent and declaration

I authorise my General Practitioner(s) or Doctor to provide the information requested on this form relevant to my fitness to drive a licensed hackney carriage or private hire vehicle to St Helens Council in order to assess my fitness to hold a hackney carriage or private hire driver 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.

Signed:

Date:

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

## General Practitioner/Doctor

**This form must be completed in full by the applicant's own GP or Doctor or a GP or Doctor who has reviewed the applicant's medical records. Please answer all questions and once completed sign the declaration at the end.**

St Helens Council's policy on medical fitness requires that hackney carriage and private hire drivers meet Group 2 Medical Standards, as set out in the DVLA publication '*Assessing fitness to drive - a guide for medical professionals*'.

This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to hackney carriage and private hire drivers.

(a)	Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?	YES	NO
(b)	Have you reviewed the above applicant's medical records? If reviewing a printout of the medical records please give date of printout:	YES	NO

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 1****Vision Assessment – to be completed by the GP or Optician/Optomtrist**

Please see the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at [www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals](http://www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals)

1	Please confirm the scale you are using to express the driver's visual acuities: <input type="checkbox"/> Snellen <input type="checkbox"/> Snellen expressed as a decimal <input type="checkbox"/> LogMAR						
					<b>YES</b>	<b>NO</b>	
2	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)				<input type="checkbox"/>	<input type="checkbox"/>	
3	Were corrective lenses worn to meet this standard? If <b>Yes</b> please indicate if: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Both				<input type="checkbox"/>	<input type="checkbox"/>	
4	<b>Uncorrected</b>		<b>Corrected (using the prescription worn for driving)</b>				
	Right	<input type="text"/>	Left	<input type="text"/>	Right	<input type="text"/>	Left
5	If <b>glasses</b> (not contact lenses) are worn for driving, is the corrective power greater than +8 dioptres in any meridian of either lens?				<input type="checkbox"/>	<input type="checkbox"/>	
6	If a correction is worn for driving, is it well tolerated?				<input type="checkbox"/>	<input type="checkbox"/>	
7	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and / or peripheral)?				<input type="checkbox"/>	<input type="checkbox"/>	
8	Is there diplopia (controlled or uncontrolled)?				<input type="checkbox"/>	<input type="checkbox"/>	
9	Does the applicant, on questioning, report symptoms of intolerance to glare and / or impaired contrast sensitivity and / or impaired twilight vision?				<input type="checkbox"/>	<input type="checkbox"/>	
10	Does the applicant have any other ophthalmic condition?				<input type="checkbox"/>	<input type="checkbox"/>	

If **YES** to questions 7, 8, 9 or 10 please give details in **Section 7**.

If eye examination has been completed by an Optician or Optometrist please give details below:

Name:

Address:

Contact telephone number:

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 2**

**NERVOUS SYSTEM**

	Is there any history of, or evidence of, <b>any</b> neurological disorder? If <b>No</b> , go to section <b>3</b>				<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	
1	Has the applicant had any form of seizure? If <b>YES</b> please answer questions a – f below.				<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	
	a	Has the applicant had more than one attack?			<input type="checkbox"/>	<input type="checkbox"/>	
	b	Please give date of first and last attack:	<i>First attack</i>	DD MM YY	<i>Last attack</i>	DD MM YY	
	c	Is the applicant currently on anti-epileptic medication? If <b>YES</b> please give details of current medication in <b>section 7</b> .				<input type="checkbox"/>	<input type="checkbox"/>
	d	If no longer treated, please give date when treatment ended.			DD MM YY		
e	Has the applicant had a brain scan? If <b>YES</b> please provide date and details in <b>Section 7</b> .				<input type="checkbox"/>	<input type="checkbox"/>	
f	Has the applicant had an EEG? If <b>YES</b> please provide date and details in <b>Section 7</b>				<input type="checkbox"/>	<input type="checkbox"/>	
2	Is there a history of blackout or impaired consciousness within the last 5 years? If <b>YES</b> please give dates and details at <b>Section 7</b> :				<input type="checkbox"/>	<input type="checkbox"/>	
3	Does the applicant suffer from narcolepsy? If <b>YES</b> please give dates and details in <b>Section 7</b> .				<input type="checkbox"/>	<input type="checkbox"/>	
4	Is there a history of, or evidence of, any of the conditions listed at a – h below? If <b>NO</b> go to <b>Section 3</b> .				<input type="checkbox"/>	<input type="checkbox"/>	
	If <b>YES</b> please give dates and full details in <b>section 7</b> .						
	a	Stroke / TIA If <b>YES</b> please give date: DD MM YY			<input type="checkbox"/>	<input type="checkbox"/>	
		Has there been a <b>FULL</b> recovery?				<input type="checkbox"/>	<input type="checkbox"/>
		Has a carotid ultrasound been undertaken?				<input type="checkbox"/>	<input type="checkbox"/>
		If <b>YES</b> , was the carotid artery stenosis >50% in either carotid artery?				<input type="checkbox"/>	<input type="checkbox"/>
	b	Sudden and disabling dizziness/vertigo within the last one year with a liability to recur				<input type="checkbox"/>	<input type="checkbox"/>
	c	Subarachnoid haemorrhage				<input type="checkbox"/>	<input type="checkbox"/>
	d	Serious traumatic brain injury within the last 10 years				<input type="checkbox"/>	<input type="checkbox"/>
	e	Any form of brain tumour				<input type="checkbox"/>	<input type="checkbox"/>
	f	Other brain surgery or abnormality				<input type="checkbox"/>	<input type="checkbox"/>
g	Chronic neurological disorders				<input type="checkbox"/>	<input type="checkbox"/>	
h	Parkinson's disease				<input type="checkbox"/>	<input type="checkbox"/>	

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

## Section 3

**DIABETES MELLITUS**

Does the applicant have diabetes mellitus?		Yes	No
If <b>NO</b> please go to Section 4.		<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> please answer the following questions.			
1	Is the diabetes managed by:-	<input type="checkbox"/>	<input type="checkbox"/>
a	Insulin? If <b>YES</b> please give date started on insulin: DD MM YY	<input type="checkbox"/>	<input type="checkbox"/>
b	If treated with insulin, are there at least 3 continuous months of blood glucose readings stored in a memory meter? If <b>NO</b> , please give details in <b>Section 7</b>	<input type="checkbox"/>	<input type="checkbox"/>
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? If <b>YES</b> please provide details of medication:	<input type="checkbox"/>	<input type="checkbox"/>
f	Diet only?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> to any of (a) – (e) above, please give details in <b>Section 7</b>			
2	a Does the applicant test blood glucose at least twice every day?	<input type="checkbox"/>	<input type="checkbox"/>
	b Does the applicant test at times relevant to driving?	<input type="checkbox"/>	<input type="checkbox"/>
	c Does the applicant keep fast acting carbohydrate within easy reach when 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	Is there any evidence of impaired 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?	<input type="checkbox"/>	<input type="checkbox"/>
5	Is there evidence of:-		
a	Loss of visual field?	<input type="checkbox"/>	<input type="checkbox"/>
b	Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>YES</b> to any or 3 – 5 above, please give details in <b>Section 7</b>			
6	Has there been any laser treatment or intra-vitreous for retinopathy? If <b>YES</b> please give date(s) of treatment: DD MM YY	<input type="checkbox"/>	<input type="checkbox"/>

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

## Section 4

**CARDIAC****4A CORONARY ARTERY DISEASE**

Is there a history of, or evidence of, Coronary Artery Disease? If **NO** please go to Section 4B.

Yes

No

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): DD MM YY

2 Coronary artery by-pass graft surgery?

If **YES** please give date(s): DD MM YY

3 Coronary Angioplasty (PCI)?

If **YES** please give date of most recent intervention: DD MM YY

4 Has the applicant suffered from angina?

If **YES** please give the date of the last known attack: DD MM YY

5 If **YES** to any of the above, are there any physical health problems (eg. Mobility/arthritis. COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?

**4B CARDIAC ARRHYTHMIA**

Is there a history of, or evidence of, cardiac arrhythmia? If **NO**, go to Section 4C If **YES** please answer all questions below and give details in **Section 7**.

Yes

No

1 Has there been a **significant** disturbance of cardiac rhythm? i.e. Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia, in 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 implanted? If **YES**:

a Please supply date:

b Is the applicant free of symptoms that caused the device to be fitted?

c Does the applicant attend a pacemaker clinic regularly?

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

4C		PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION				
Is there a history or evidence of <b>ANY</b> of the conditions listed at 1 – 5 below? If <b>NO</b> go to Section 4D. If <b>YES</b> please answer the questions below and give details in <b>Section 7</b>				Yes <input type="checkbox"/>	No <input type="checkbox"/>	
1	Peripheral Arterial Disease (excluding Buerger's Disease)			<input type="checkbox"/>	<input type="checkbox"/>	
2	Does the applicant have claudication? If <b>YES</b> , how long in minutes can the applicant walk at a brisk pace before being symptom limited?:			<input type="checkbox"/>	<input type="checkbox"/>	
3	Aortic Aneurysm If <b>YES</b> :			<input type="checkbox"/>	<input type="checkbox"/>	
	a	Site of Aneurysm (please tick):	Thoracic <input type="checkbox"/>	Abdominal <input type="checkbox"/>		
	b	Has it been repaired successfully?			<input type="checkbox"/>	<input type="checkbox"/>
	c	Is the transverse diameter <b>currently</b> >5.5cm?			<input type="checkbox"/>	<input type="checkbox"/>
		If <b>NO</b> please provide latest measurement:		Date obtained: DD MM YY		
4	Dissection of the Aorta repaired successfully. If <b>YES</b> , please provide details in <b>Section 7</b>			<input type="checkbox"/>	<input type="checkbox"/>	
5	Is there history of Marfan's disease? If <b>YES</b> , please provide details in <b>Section 7</b>			<input type="checkbox"/>	<input type="checkbox"/>	
4D		VALVULAR/CONGENITAL HEART DISEASE				
Is there a history of, or evidence of, valvular/congenital heart disease?				Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If <b>NO</b> go to Section 4E. If <b>YES</b> please answer all questions below and give details in <b>Section 7</b>						
1	Is there a history of congenital heart disorder?			<input type="checkbox"/>	<input type="checkbox"/>	
2	Is there a history of heart valve disease?			<input type="checkbox"/>	<input type="checkbox"/>	
3	Is there a history of aortic stenosis?			<input type="checkbox"/>	<input type="checkbox"/>	
4	Is there any history of embolism? (not pulmonary embolism)			<input type="checkbox"/>	<input type="checkbox"/>	
5	Does the applicant currently have significant symptoms?			<input type="checkbox"/>	<input type="checkbox"/>	
6	Has there been any progression since the last licence application? (if relevant)			<input type="checkbox"/>	<input type="checkbox"/>	
4E		CARDIAC OTHER				
Does the applicant have a history of <b>ANY</b> of the following conditions? If <b>NO</b> go to Section 4F. If <b>YES</b> please answer <b>ALL</b> questions below and give details in <b>Section 7</b>				Yes <input type="checkbox"/>	No <input type="checkbox"/>	
a	A history of, or evidence of, heart failure?			<input type="checkbox"/>	<input type="checkbox"/>	
b	Established cardiomyopathy?			<input type="checkbox"/>	<input type="checkbox"/>	
c	Has a left ventricular assist device (LVAD) been implanted?			<input type="checkbox"/>	<input type="checkbox"/>	
d	A heart or heart/lung transplant?			<input type="checkbox"/>	<input type="checkbox"/>	
e	Untreated atrial myxoma?			<input type="checkbox"/>	<input type="checkbox"/>	

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>4F</b>	<b>CARDIAC CHANNELOPATHIES</b>
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Is there a history of, or evidence of either of the following conditions? If <b>No</b> , go to section 4G	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
1 Brugada syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
2 Long QT syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>Yes</b> to either, please give details in <b>section 7</b>		

<b>4G</b>	<b>BLOOD PRESSURE (This section must be filled in for all applicants)</b>
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1	Please record today's <b>best resting</b> blood pressure reading:			
2	Is the applicant on anti-hypertensive treatment?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	
	If <b>YES</b> please provide three previous readings with dates if available:			
1	B.P. reading:	Date:	DD MM YY	
2	B.P. reading:	Date:	DD MM YY	
3	B.P. reading:	Date:	DD MM YY	
3	Is there history of malignant hypertension? If <b>Yes</b> , please provide details in section 7 (including date of diagnosis and any treatment etc)	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	

<b>4H</b>	<b>CARDIAC INVESTIGATIONS (This section must be filled in for all applicants)</b>
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	Have any cardiac investigations been undertaken or planned? If <b>No</b> , go to section 5 If <b>Yes</b> , please answer questions 1 - 6	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
1	Has a resting ECG been undertaken? If <b>YES</b> does it show:	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
a	Pathological Q waves?	<input type="checkbox"/>	<input type="checkbox"/>
b	Left bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
c	Right bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>Yes</b> to a, b or c please provide details in <b>section 7</b>		
2	Has the exercise ECG been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> please provide date and give details in <b>Section 7</b> DD MM YY		
3	Has an echocardiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
a	If <b>YES</b> please give date and give details in <b>Section 7</b> DD MM YY		
b	If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?	<input type="checkbox"/>	<input type="checkbox"/>
4	Has a coronary angiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>

GP Signature \_\_\_\_\_ Date \_\_\_\_\_



	If <b>YES</b> please provide date and give details in <b>Section 7:</b> DD MM YY		
5	Has a 24 hour ECG tape been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> please provide date and give details in <b>Section 7</b> DD MM YY		
6	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
	If <b>YES</b> please provide date and give details in <b>Section 7</b> DD MM YY		

### Section 5

#### PSYCHIATRIC ILLNESS

Is there a history of, or evidence of <b>ANY</b> of the conditions listed at 1 – 9 below? If <b>NO</b> please go to Section 6.		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
If <b>YES</b> please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in <b>Section 7</b> . (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in <b>Section 7</b> ).			
1	Significant psychiatric disorder within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
2	Psychosis or hypomania/mania within the past 3 years, including psychotic depression?	<input type="checkbox"/>	<input type="checkbox"/>
3	Dementia or cognitive impairment?	<input type="checkbox"/>	<input type="checkbox"/>
4	Persistent alcohol misuse in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5	Alcohol dependence in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>
6	Does the applicant show any evidence of being addicted to the excessive use of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
7	Persistent drug misuse in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8	Does the applicant show any evidence of being addicted to the excessive use of drugs?	<input type="checkbox"/>	<input type="checkbox"/>
9	Drug dependency in the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 6**
**GENERAL**

Please answer all questions in this section. If your answer is **YES** to any question please give full details in **Section 7**.

1	Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
	If <b>YES</b> please give diagnosis:		
a	<p>If Obstructive Sleep Apnoea Syndrome, please indicate the severity</p> <p>Mild (AHI&lt;15)           <input type="checkbox"/></p> <p>Moderate (AHI 15 – 29) <input type="checkbox"/></p> <p>Severe (AHI &gt;29)       <input type="checkbox"/></p> <p>Not known               <input type="checkbox"/></p> <p>If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. Please give details in <b>section 7</b></p>		
b	Please answer questions (i) to (vi) for <b>all</b> sleep conditions		
(i)	Date of diagnosis:       DD MM YY		
(ii)	Is it controlled successfully?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
(iii)	If <b>Yes</b> please state treatment:		
(iv)	Is patient compliant with treatment	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
(v)	Please state period of control:		
(vi)	Date of last review:       DD MM YY		
2	Is there <b>currently</b> any functional impairment that is likely to affect control of the vehicle?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
3	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
4	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
5	Is the applicant profoundly deaf?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
	If <b>YES</b> is the applicant able to communicate in the event of an emergency by speech or by using a device, eg. a textphone?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
6	Does the applicant have a history of liver disease of any origin? If <b>YES</b> please provide details in <b>Section 7</b> .	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
7	Is there any history of renal failure? If <b>YES</b> please provide details in <b>Section 7</b> .	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
8	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
9	Does any medication currently taken cause the applicant side effects that could affect safe driving? If <b>YES</b> please provide details of medication and symptoms in <b>Section 7</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

10	Does the applicant have any other medical condition that could affect safe driving? If <b>YES</b> please provide details in <b>Section 7</b>	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
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GP Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 7**

Additional Information

**PLEASE ENSURE YOU COMPLETE AND SIGN THE LAST PAGE OF THIS MEDICAL ASSESSMENT**

GP Signature \_\_\_\_\_ Date \_\_\_\_\_

**General Practitioner Declaration:**

Please read the following carefully before completing, signing and dating the declaration.

If the applicant is not a registered patient with your practice or you have not reviewed their medical record's then **DO NOT** complete the declaration.

I certify that;

- I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a hackney carriage or private hire vehicle under the **DVLA Group 2 Medical Standards**
- I have reviewed the applicant's medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.
- The medical examination today is satisfactory. From the applicant's medical records and from today's examination, I know of no medical reason where the applicant would be advised to inform the DVLA with regards to driver licensing requirements under Group 2 standards.

Surgery / Medical Centre Name:

Surgery / Medical Centre Stamp:  
FORM WILL NOT BE ACCEPTED WITHOUT AN OFFICIAL STAMP

Surgery / Medical Centre Address:

GP's Name:  
PLEASE PRINT IN BLOCK CAPITALS

GP's Signature:

Date:

GP Signature \_\_\_\_\_ Date \_\_\_\_\_