STOCKPORT
METROPOLITAN BOROUGH COUNCIL

Taxi Licensing
Fred Perry House, Edward Street,
Stockport, SK1 3XE
Direct Line: 0161 474 3264
Fax: 0161 474 4369
Email: taxi.licensing@stockport.gov.uk

MEDICAL REPORT IN SUPPORT OF AN APPLICATION FOR A TAXI OR LICENSED HIRE CAR DRIVER'S LICENCE

Applicants must ensure ALL sections are completed and SIGNED before submitting to Taxi Licensing. This form must also be endorsed by the Practice Stamp.

NOTES

1. Information about the Applicant (Part A)

To be completed by the applicant and signed in the presence of the medical practitioner.

This medical report cannot be issued free of charge as part of the NHS. The applicant must pay the practitioners fee and the Council accepts no liability for this charge.

2. Medical Report (Part B)

To be completed by the applicant's General Practitioner, or a Doctor who has access to the applicant's medical history and records. The report will not be accepted if it is completed by any other person.

When completing this medical report, please have regard to the 'At a glance guide to the current medical standards of fitness to drive' notes for guidance issued by the DVLA for medical practitioners. The medical standard to be applied is Group 2. Current best practice advice is contained in the booklet 'Fitness to Drive'; A Guide for Health Professionals published on behalf of the DVLA by the Royal Society of Medicine Press Ltd (RSM) in 2006. There is also further guidance from the DVLA on the gov.uk website and DVLA website.

Please tick under the 'yes' or 'no' column, as appropriate. Use the right hand margin if you want to add anything or write "see note attached" and use separate sheet of paper which should be attached to this form.

PART A – INFORMATION ABOUT THE APPLICANT

<table>
<tr><td>Surname</td><td colspan="2"></td><td>First Name(s)</td><td></td></tr>
<tr><td rowspan="2">Home address (including postcode)</td><td colspan="4"></td></tr>
<tr><td colspan="2"></td><td>Postcode</td><td></td></tr>
<tr><td>Date of birth</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td rowspan="6">Name and address of current Doctor and Practice</td><td>GP name</td><td colspan="3"></td></tr>
<tr><td>Practice name</td><td colspan="3"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="2"></td><td>Postcode</td><td></td></tr>
</table>

State how long you have been registered with this GP	Years Months

You should be aware that if you have knowingly given false information in this examination you are liable to prosecution.

By signing this you declare that you have checked the details and that to the best of your knowledge and belief they are correct. If a medical condition is declared, you authorise your Doctor(s) and Specialist(s) to release reports to Stockport Council and their medical advisor about your condition.

Applicant's Signature .....……..….

Please sign in the presence of the medical practitioner who signs the report (Part B)

☐ Please tick the box if you require this form to be returned to you.

PART B – MEDICAL REPORT

	YES	NO	COMMENTS
1. CARDIOVASCULAR			
(a) Is there any history of cardiac infarction (coronary thrombosis), any persisting anginal pain or any current need of treatment of anginal pain?	☐	☐	
(b) Is there any other evidence, including ECG, of ischaemic heart disease?	☐	☐	
(c) Is there any history or evidence of arrhythmia (excluding extrasystoles which disappear on effort)?	☐	☐	
(d) Is the blood pressure 200/110 or over?	☐	☐	
(e) Is hypertension treated by medication other than a diuretic or beta blocker?	☐	☐	
(f) Is a cardiac pacemaker fitted?	☐	☐	
(g) Is there a history of current intermittent claudication?	☐	☐	
(h) Is there a history of open heart or vascular surgery?	☐	☐	
2. ENDOCRINE SYSTEM Is the applicant a diabetic treated by insulin injection?	☐	☐	
3. EPILEPSY Has the applicant suffered an attack of epilepsy since attaining the age of 5 years?	☐	☐	
4. NERVOUS SYSTEM (a) Is there any progressive disorder of the nervous system?	☐	☐	
	☐	☐	

(b) Is there any history of one or more transient ischaemic attacks or cerebrovascular accidents? (c) Is there a history of a severe head injury or major craniotomy? (d) Is there any hearing defect to the extent of preventing communication by telephone?	☐ ☐	☐ ☐	
5. PSYCHIATRIC ILLNESS (a) Is there a history of psychosis? (b) Is there abuse of alcohol or drugs?	☐ ☐	☐ ☐	
6. VISION (If you do not have the equipment to carry out these checks, then you should refer the applicant to an opthalmic specialist or optician) (a)Has the applicant had a cataract removed? (b) Is the visual acuity, using corrective lenses if necessary: (i) less than 6/12 in worse eye and 6/9 in the better eye? (ii) if 'Yes' is it less than 6/36 and 6/12 respectively. (c) Has the patient monocular vision? (d) Is there insuperable diplopia or a pathological field defect?	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
7. MUSCULOSKELETAL SYSTEM Has the applicant any condition or physical disability (with special attention paid to the condition of the arms, legs, hands and joints) which is likely to interfere with the efficient discharge of his / her duties as a vocational driver? If 'Yes' please specify	☐	☐	
8. OTHER CONDITIONS Does the applicant suffer form any disease or disability not mentioned above which is likely to interfere with the efficient discharge of his or her duties as a driver, or to cause driving by him or her on a vocational licence to be a source of danger to the public.	☐	☐	

If 'Yes' please specify			

I confirm that I have access to the applicant's full medical history and records Yes ☐ No ☐

I consider the applicant ☐ FIT to be either a taxi or licensed hire car driver.

☐ UNFIT

Signed …… Date……
Registered Medical Practitioner

Registered Medical Practitioner Name (BLOCK CAPITALS) ……

Telephone number……..

SURGERY STAMP: