Rossendale
BOROUGH COUNCIL

Certificate of fitness to drive
A Hackney Carriage or Private Hire vehicle

When completing this medical report and certificate, please have regard to the DVLA's *"At a glance guide to the current medical standards of fitness to drive"* and the Medical Commission's accident prevention booklet *"Medical aspects of fitness to drive"*. The main purpose of the medical report is to ascertain that the client is fit to drive and any additional information should only be disclosed to advise on recommended length of fitness (eg, insulin dependent diabetic).

Applicants who may be symptom free at the time of the examination should be advised that if, in future, they develop symptoms of a condition which could affect safe driving and they hold any type of licence they must inform the Council.

Any additional information not relevant to the below two instances are not to be disclosed. The medical practitioner must determine from the completed medical whether the applicant is or is not fit to drive under Group 2 standards.

Applicant Name: _____

Date of Birth: _____

Being a registered Medical Practitioner who is competent in undertaking DVLA Group 2 medical examinations, I have today examined the above applicant. I have examined the applicant medically to the DVLA Group 2 medical standards for Vocation Drivers and I consider the above applicant *;

**Please tick relevant box*

☐ **MEETS** the DVLA Group 2 medical standards for vocational drivers.

☐ **DOES NOT MEET** the DVLA Group 2 medical standards for vocational drivers.

I confirm that the above applicant is registered with this surgery and has been registered since

_____ *(date)*.

Signed: _____ **Date:** _____

Name: _____
(BLOCK CAPITALS)

Surgery Stamp

Driver & Vehicle Licensing Agency

Medical examination report for a Group 2 (lorry or bus) licence

D4

If this form is not fully completed it will be returned and the application will be delayed.

For information about completing the form read the leaflet INF4D. This can also be viewed in PDF format at **www.gov.uk/reapply-driving-licence-medical-condition**

All black outlined boxes must be answered

Pages 1 and 8 must be completed by the applicant

Your name _____

Address & postcode _____

_____

Date of birth _____

Daytime contact phone number _____

Email address _____

Date first licenced to drive a lorry (if known) _____

Date first licenced to drive a bus (if known) _____

Your doctor's details

Name of doctor _____

Address & postcode _____

_____

Phone number _____

Email (if known) _____

You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.

CUSTOMER SERVICE EXCELLENCE CSE

Driver & Vehicle Licensing Agency

Medical examination report

Vision assessment

To be filled in by a doctor or optician/optometrist

D4

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.

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		Corrected (using prescription worn for driving)	
R	L	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? **YES** ☐ **NO** ☐

If **YES**, glasses ☐ contact lenses ☐ both together ☐

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? **YES** ☐ **NO** ☐

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.

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 field testing is considered necessary, DVLA will commission this at a later date

8. Is there diplopia? **YES** ☐ **NO** ☐

(a) If **YES**, is it controlled? ☐ ☐

If **YES**, please give full details in the box provided

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? **YES** ☐ **NO** ☐

If **YES**, please give full details in the box provided

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature D D M M Y Y

Please provide your GOC, HPC or GMC number

Doctor/optometrist/optician's stamp

Applicant's full name **Date of birth** D D M M Y Y

Please do not detach this page

Driver & Vehicle Licensing Agency

Medical examination report
Medical assessment
Must be filled in by a doctor

D4

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant as well as taking the applicant's history.

1 Nervous system

Please tick ✓ the appropriate box(es)

Is there a history of, or evidence of **any** neurological disorder? YES ☐ NO ☐

If **NO**, go to section **2**

If **YES**, please answer **ALL** questions below

		YES	NO
1.	Has the applicant had any form of seizure?	☐	☐
	(a) Has the applicant had more than one attack?	☐	☐
	(b) Please give date of first and last attack		
	First attack D D M M Y Y		
	Last attack D D M M Y Y		
	(c) Is the applicant currently on anti-epileptic medication? If **YES,** please fill in current medication in **section 8, page 7**	☐	☐
	(d) If no longer treated, please give date when treatment ended D D M M Y Y		
	(e) Has the applicant had a brain scan? If **YES,** please give details in **section 6, page 6**	☐	☐
	(f) Has the applicant had an EEG? If **YES** to any of above, please supply reports if available.	☐	☐

Is there **ANY** history of the following:

		YES	NO
2.	Stroke or TIA?	☐	☐
	If **YES,** please give date D D M M Y Y		
	Has there been a **FULL** recovery?	☐	☐
	Has a carotid ultra sound been undertaken?	☐	☐
3.	Sudden and disabling dizziness/vertigo within the last year with a liability to 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 disorders?	☐	☐
9.	Parkinson's disease?	☐	☐
10.	Is there a history of blackout or impaired consciousness within the last 5 years? If **YES, please give date(s) and details in section 6, page 6**	☐	☐
11.	Does the applicant suffer from narcolepsy? If **YES, please give date(s) and details in section 6, page 6**	☐	☐

2 Diabetes mellitus

Does the applicant have diabetes mellitus? YES ☐ NO ☐

If **NO**, go to section 3, page 4

If **YES**, please answer ALL the following questions.

		YES	NO
1.	Is the diabetes managed by:		
	(a) Insulin? If **YES**, please give date started on insulin D D M M Y Y	☐	☐
	(b) If treated with insulin, are there at least 3 months of blood glucose readings stored on a memory meter(s)? If **NO**, please give details in **section 6, page 6**	☐	☐
	(c) Other injectable treatments?	☐	☐
	(d) A Sulphonylurea or a Glinide?	☐	☐
	(e) Oral hypoglycaemic agents and diet? If **YES** to any of a-e, please fill in current medication in **section 8, page 7**	☐	☐
	(f) Diet only?	☐	☐
2.	(a) Does the applicant test blood glucose at least twice every day?	☐	☐
	(b) Does the applicant test at times relevant to driving?	☐	☐
	(c) Does the applicant keep fast acting carbohydrate within easy reach when driving?	☐	☐
	(d) Does the applicant have 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.	Is there evidence of:	☐	☐
	(a) Loss of visual field?	☐	☐
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? If **YES** to any of 4-6 above, please give details in **section 6, page 6**	☐	☐
6.	Has there been laser treatment or intra-vitreal treatment for retinopathy? If **YES**, please give date(s) of treatment.	☐	☐

Applicant's full name _____ **Date of birth** D D M M Y Y

3 Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years? YES ☐ NO ☐

If **NO**, go to **section 4**

If **YES**, please answer ALL questions below

1. Significant psychiatric disorder within the past 6 months? YES ☐ NO ☐
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? YES ☐ NO ☐
3. Dementia or cognitive impairment? YES ☐ NO ☐
4. Persistent alcohol misuse in the past 12 months? YES ☐ NO ☐
5. Alcohol dependence in the past 3 years? YES ☐ NO ☐
6. Persistent drug misuse in the past 12 months? YES ☐ NO ☐
7. Drug dependence in the past 3 years YES ☐ NO ☐

If 'YES' to any questions above, please provide full details in section 6, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

4 Cardiac

a Coronary artery disease

Is there a history of, or evidence of, coronary artery disease? YES ☐ NO ☐

If **NO,** go to **section 4b**

If **YES,** please answer ALL questions below and give details at **section 6** of the form and enclose relevant hospital notes.

1. Has the applicant suffered from angina? YES ☐ NO ☐

   If **YES**, please give the date of the last known attack D D M M Y Y
2. Acute coronary syndrome including myocardial infarction? YES ☐ NO ☐

   If **YES**, please give date D D M M Y Y
3. Coronary angioplasty (P.C.I.)? YES ☐ NO ☐

   If **YES**, please give date of most recent intervention D D M M Y Y
4. Coronary artery by-pass graft surgery? YES ☐ NO ☐

   If **YES**, please give date D D M M Y Y

b Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? YES ☐ NO ☐

If **NO**, go to **section 4c**

If **YES**, please answer ALL questions below and give details in **section 6, page 6**.

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 the last 5 years YES ☐ NO ☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? YES ☐ NO ☐
3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted? YES ☐ NO ☐
4. Has a pacemaker been implanted? YES ☐ NO ☐

   If **YES:**

   (a) Please supply date of implantation D D M M Y Y

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

   (c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection? YES ☐ NO ☐

If **NO**, go to **section 4d**

If **YES**, please answer ALL questions below and give details in **section 6 page 6,** enclosing relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease) YES ☐ NO ☐
2. Does the applicant have claudication? YES ☐ NO ☐

   If **YES**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?

   Please give details
3. Aortic aneurysm? YES ☐ NO ☐

   If **YES:**

   (a) Site of Aneurysm: Thoracic ☐ Abdominal ☐

   (b) Has it been repaired successfully? ☐ ☐

   (c) Is the transverse diameter **currently** > 5.5 cm? ☐ ☐

   If **NO**, please provide latest measurement and date obtained

   D D M M Y Y
4. Dissection of the aorta repaired successfully? YES ☐ NO ☐

   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? YES ☐ NO ☐

   If **YES**, please provide relevant hospital notes

Applicant's full name **Date of birth** D D M M Y Y

d Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? YES ☐ NO ☐

If **NO**, go to **section 4e**

If **YES**, please answer ALL questions below and give details in **section 6 page 6.**

1. Is there a history of congenital heart disease? YES ☐ NO ☐
2. Is there a history of heart valve disease? YES ☐ NO ☐
3. Is there a history of aortic stenosis? YES ☐ NO ☐
   If **YES**, please provide relevant reports
4. Is there any history of embolism? (**not** pulmonary embolism) YES ☐ NO ☐
5. Does the applicant currently have significant symptoms? YES ☐ NO ☐
6. Has there been any progression since the last licence application? (if relevant) YES ☐ NO ☐

e Cardiac other

Is there a history of, or evidence of heart failure? YES ☐ NO ☐

If **NO,** go to **section 4f**

If **YES,** please answer ALL questions below

1. Established cardiomyopathy? YES ☐ NO ☐
2. Has a left ventricular assist device (LVAD) been implanted? YES ☐ NO ☐
3. A heart or heart/lung transplant? YES ☐ NO ☐
4. Untreated atrial myxoma? YES ☐ NO ☐

f Cardiac investigations

Have any cardiac investigations been undertaken or planned? YES ☐ NO ☐

If **NO,** go to **section 4g**

If **YES,** please answer ALL questions

1. Has a resting ECG been undertaken? YES ☐ NO ☐
   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, page 6**.*
2. Has an exercise ECG been undertaken (or planned)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6** D D M M Y Y
   Please provide relevant reports if available
3. Has an echocardiogram been undertaken (or planned)? YES ☐ NO ☐
   (a) If **YES**, please give date and give details in **section 6, page 6**. D D M M Y Y
   (b) If undertaken, is/was the left ejection fraction greater than or equal to 40%? ☐ ☐
   Please provide relevant reports if available
4. Has a coronary angiogram been undertaken (or planned)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6**. D D M M Y Y
   Please provide relevant reports if available
5. Has a 24 hour ECG tape been undertaken (or planned)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6**. D D M M Y Y
   Please provide relevant reports if available
6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? YES ☐ NO ☐
   If **YES**, please give date and give details in **section 6, page 6**. D D M M Y Y
   Please provide relevant reports if available

g Blood pressure

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

1. Please record today's **best** blood pressure reading ☐
2. Is the applicant on anti-hypertensive treatment? YES ☐ NO ☐
   If **YES**, please provide three previous readings with dates if available
   ☐ D D M M Y Y
   ☐ D D M M Y Y
   ☐ D D M M Y Y

Applicant's full name ☐ **Date of birth** D D M M Y Y

5 General

All questions MUST be answered

If **YES** to any, give full details in section 6,

1. Is there **currently** any functional impairment that is likely to affect control of the vehicle? **YES** ☐ **NO** ☐

2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? **YES** ☐ **NO** ☐

3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? **YES** ☐ **NO** ☐

4. Is the applicant profoundly deaf? **YES** ☐ **NO** ☐

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

5. Does the applicant have a history of liver disease of any origin? **YES** ☐ **NO** ☐

   If **YES,** please give details in **section 6**

6. Is there a history of renal failure? **YES** ☐ **NO** ☐

   If **YES,** please give details in **section 6**

7. Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive sleepiness? **YES** ☐ **NO** ☐

   If **YES**, please give diagnosis

   a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity

   Mild (AHI <15) ☐

   Moderate (AHI 15 - 29) ☐

   Severe (AHI >29) ☐

   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 clincal issue. Please give details in section 6.

   b) Please answer questions i – vi for ALL sleep conditions

   (i) Date of diagnosis D D M M Y Y **YES** ☐ **NO** ☐

   (ii) Is it controlled successfully? ☐ ☐

   (iii) If **YES**, please state treatment

   YES ☐ **NO** ☐

   (iv) Is applicant compliant with treatment? ☐ ☐

   (v) Please state period of control

   (vi) Date of last review D D M M Y Y

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? **YES** ☐ **NO** ☐

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? **YES** ☐ **NO** ☐

   If **YES**, please provide details of medication and symptoms in **section 6**

10. Does the applicant have an ophthalmic condition? **YES** ☐ **NO** ☐

    If **YES**, please provide details in **section 6**

11. Does the applicant have any other medical condition that could affect safe driving? **YES** ☐ **NO** ☐

    If **YES**, please provide details in **section 6**

6 Further details

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

Applicant's full name **Date of birth** D D M M Y Y

7 Consultants' details

Details of type of specialist(s)/consultants, including address.

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

8 Medication

Please provide details of all current medication (continue on a separate sheet if necessary)

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

9 Additional information

Patient's weight (kg)	
Height (cms)	
Details of smoking habits, if any	
Number of alcohol units taken each week	

10 Examining doctor's details

To be completed by the doctor carrying out the examination.

Please ensure all sections of the form have been completed. Failure to do so will result in the form being returned to you.

Please print name and address in capital letters

Name

Address

Phone

Fax

Email

I confirm that this report was completed by me at examination and that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside of the UK.

Signature of practitioner

Date of signature D D M M Y Y

GMC registration number

Doctors stamp

Applicant's full name **Date of birth** D D M M Y Y

This page must be completed by the applicant

Applicant's consent and declaration

You **MUST** fill in this section and must **NOT** alter it in any way.
Please read the following important information carefully then sign to confirm the statements below.

Important information about consent

As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your background medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

Consent and declaration

I authorise my doctor(s) and specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and panel members.

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.

I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.

Name _____

Signature _____

Date _____

I authorise the Secretary of State to:	**YES**	**NO**
Inform my doctors about the outcome of my case	☐	☐
Release reports to my doctor(s)	☐	☐

Check list	**YES**
■ Have you signed and dated the consent and declaration?	☐
■ Have you checked that the report has been fully filled in by the optician/doctor?	☐

This report must be completed no more than 4 months before the date your application is received at DVLA and must be returned with your application form.