



RIBBLE VALLEY BOROUGH COUNCIL

MANDATORY GROUP 2 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 CAN BE COMPLETED BY YOUR **OWN GENERAL PRACTITIONER** WITH WHOM YOU ARE REGISTERED WITH OR ANY OTHER GP WITHIN THE SAME PRACTICE WHO HAS **FULL ACCESS** TO YOUR RECORDS.

OR COMPLETED BY AN ALTERNATIVE GP/MEDICAL PRACTITIONER WHO HAS **FULL ACCESS** TO YOUR SUMMARY OF MEDICAL RECORDS.

YOU ARE RESPONSIBLE FOR ANY FEES CHARGED BY YOUR GP/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 <https://www.gov.uk/government/publications/d4-medical-examiner-report-for-a-lorry-or-bus-driving-licence> **medical examination report for a lorry or bus driving licence (D4) - GOV.UK (www.gov.uk)**

IT IS RIBBLE VALLEY BOROUGH COUNCIL'S CONDITIONS THAT A MANDATORY GROUP 2 MEDICAL BE IN FORCE

SECTION 1 – THE APPLICANT

Full name	
Date of Birth	
Address and postcode	
Telephone Number and Email address	

Applicant's Consent and Declaration**Consent and Declaration**

Please read the following important information carefully then sign and date the statement below

On occasion, as part of the investigation into your fitness to drive a hackney carriage or private hire vehicle, Ribble Valley Borough Council may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your medical background details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only 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 members of the Council's Licensing Committee. Such information would be subject to legal restrictions on confidentiality.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports to Ribble Valley Borough Council as Licensing Authority about my condition.

I authorise Ribble Valley Borough Council to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to all those involved in the determination of my application for a licence, and to release to my Doctor(s) details of the outcome of my case and any relevant medical information.

I declare that I have checked the details I have given on this form and that, to the best of my knowledge and belief, they are correct.

Signature

Date

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

First Name

Surname

Surgery Address

Phone Number

Email address

GP (Doctor) Signature

Driver Identification (to be completed by the doctor carrying out the examination)

Documents seen

Passport

YES/NO

DVLA Drivers Photo Card

YES/NO

Verified against patient records

Applicants Date of Birth

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 <input type="checkbox"/>	NO <input type="checkbox"/>
Is the applicant currently seeing a specialist or consultant ?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Current medication including exact dosage and reason for each treatment	Continue on Page 7 if necessary	
VISION		
Is the visual acuity at least 6/9 in the better eye and at least 6/ 12 in the other? (corrective lenses may be worn) as measured with the full size 6m snellen chart	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Do corrective lenses have to be worn to achieve this standard?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, is the uncorrected acuity at least 3/ 60 in the right eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, is the uncorrected acuity at least 3/ 60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, is the correction well tolerated	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Please state the visual acuities of each UNCORRECTED eye in terms of the 6m Snellen chart. Please convert any 3 metre readings to the 6 metre equivalent.	LEFT	RIGHT
Please state the visual acuities of each CORRECTED eye in terms of the 6m Snellen chart (if applicable) Please convert any 3 metre readings to the 6 metre equivalent.	LEFT	RIGHT
Is there a defect in his/her binocular field of vision (central and/or peripheral)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is there diplopia? (controlled or uncontrolled)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does the applicant have any other ophthalmic condition?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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? <ul style="list-style-type: none"> • Stroke/ TIA (<i>please delete as appropriate</i>) • Sudden and disabling dizziness/vertigo within the last 1 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 	YES ■	NO ■
	If yes, please give details at the end of this report	
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		
<p>Is there a history of, or evidence of any of the conditions listed below?</p> <ul style="list-style-type: none"> • 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 ■	NO ■
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 PERIPHERAL 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 ■
<p>Does the applicant have a history of ANY of the following conditions:</p> <ul style="list-style-type: none"> • 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 (or planned)?	YES ■	NO ■
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 today's 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 ■	NO ■

	If yes, please give full details at the end of this report.	
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

General Practitioner (Doctor) Declaration

Name of Applicant

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

Please tick:-

I am the named applicants GP/Medical Practitioner with full access to the applicants NHS records/summary of medical records at the time of the examination.

I am a GP/medical Practitioner with full access to the applicants NHS records/summary of medical records at the time of the examination in the applicant's practice.

I am a GP/medical Practitioner with access to the applicants NHS records/summary of medical records at the time of the examination.

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

Has met

Has not met

Group 2 Standards of medical fitness, as applied by the DVLA to the licensing of lorry & bus drivers which is required for licence 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 any relevant details.

I CONSIDER THE APPLICANT SHOULD BE SUBJECT TO A FURTHER MEDICAL EXAMINATION IN:

(Please tick)

5 years

3 years

1 year

NOTE

All drivers who attain 65 years of age are required to undergo an annual medical examination

Full Name of GP and Signature of Qualified & Registered Medical Practitioner

Date

SURGERY STAMP: