MEDICAL EXAMINATION GUIDANCE
for a hackney carriage/private hire drivers licence

When making an application for either a hackney carriage or private hire driver’s licence, you must be able to demonstrate that you are medically fit to drive by having a medical check with a doctor.

Once you have obtained a licence, you will need to undergo further medical checks at the age of 45 then every 5 years until the age of 65. After 65 you will need to have a medical every year.

Additionally, you may be required to have a medical outside of these times if your medical fitness changes.

Requirements for medical examinations

1. You must arrange an appointment with a GP to have your medical carried out.

2. You must complete the HC/PH Driver Medical Fitness Declaration found overleaf prior to attending your medical and then sign applicant consent and declaration at back of form.

3. Your medical examination must adhere to the DVLA’s Group 2 Entitlement. Please refer to DVLA’s “At a Glance Guide to the current Medical Standards of Fitness to Drive” for further information. –This can be found at: www.dft.gov.uk/dvla/medical/ataglance

4. You must declare any medication that you have been prescribed.

5. The GP must complete the declaration form at the end of the medical form to confirm whether you are fit to drive a licensed hackney carriage and/or a private hire vehicle.

All fees associated with the medical examination are payable direct by you. The Council is not responsible for fees and charges levied by your doctor.

What you have to do

Medical standards for professional drivers are stricter than for ordinary car drivers. If you have any concerns about your ability to meet the medical or eyesight standards, please speak to your doctor/optician before you make arrangements for a medical check with a doctor.

Please return this form to:
(If sending form via post we recommend that you either keep a copy of the completed form or send via recorded delivery to ensure receipt)

Fleet Compliance Team
Environmental Services
Wiltshire Council
County Hall
Bythesea Road
Trowbridge
Wiltshire
BA14 8JN
Tel: 01225 770271 Email: fleet.licensing@wiltshire.gov.uk
# Hackney Carriage/Private Hire Driver Medical Fitness Declaration

Please advise if you have any of the following health issues:

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Epilepsy, Fits or blackouts</td>
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<tr>
<td>Repeated attacks of sudden disabling giddiness (dizziness that prevents you from functioning normally)</td>
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<td>Diabetes controlled by insulin</td>
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<td>Diabetes controlled by tablets</td>
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<td>An implanted cardiac pacemaker and / or An implanted cardiac defibrillator (ICD)</td>
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<td>Persistent alcohol and / or drug abuse or dependency</td>
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<td>Parkinson’s disease</td>
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<td>Narcolepsy or sleep apnoea syndrome</td>
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<td>Stroke, with any symptoms lasting longer than one month, including recurrent ‘mini strokes’ or TIAs (Transient Ischaemic Attacks)</td>
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<td>Any type of brain surgery, severe head injury involving inpatient treatment, or brain tumour</td>
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<tr>
<td>Any other chronic (long term) neurological condition</td>
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<td>A serious problem with memory or episodes of confusion</td>
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<td>Severe learning disability</td>
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<td>Serious psychiatric illness or mental ill-health</td>
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<td>Total loss of sight in one eye</td>
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<td>Any condition affecting both eyes, or the remaining eye only (not including short or long sight or colour blindness)</td>
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<td>Any condition affecting your visual field (the surrounding area you can see when looking directly ahead)</td>
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<td>Visual problems affecting either eye</td>
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<tr>
<td>Any persistent limb problem for which your driving has to be restricted to certain types of vehicles or those with adapted controls</td>
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<td>Angina, other heart conditions or heart operation</td>
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<tr>
<td>Any other condition that may affect driving. Please provide details below:</td>
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If any of the above changes, I will inform the Fleet Compliance Team as soon as possible. I understand that I must also inform DVLA by writing to the: Drivers Medical Group, DVLA, Swansea SA99 1TU (the appropriate medical questionnaires can be downloaded from www.direct.gov.uk/driverhealth). Failure to do so is a criminal offence punishable by a fine of up to £1,000.

I have read and understood the medical requirements for hackney carriage and/or private hire driver licences and have been made aware of the latest version of the Wiltshire Council Guidelines for hackney carriage/private hire drivers, hackney carriage vehicles, private hire vehicles and private hire operators, these can be downloaded from our website at: [http://www.wiltshire.gov.uk/licences-permits-transport](http://www.wiltshire.gov.uk/licences-permits-transport).

I declare that the information contained in this document is true. I understand making a false declaration is a serious matter which can lead to a review of my hackney carriage and/or private hire driver licence, or in the case of a new applicant, refusal to grant a hackney carriage and/or private hire driver licence.

Print Name:  
Signature:  
Date:
If this form is not fully completed we will return it to you and your application will be delayed. For information about completing the form read the leaflet INF4D. This is also available at www.gov.uk/reapply-driving-licence-medical-condition

Your details (applicant)

Name ____________________________________________________________________________

Full address ________________________________________________________________________
___________________________________________________________________________________

Daytime phone number _______________________________________________________________

Email address _______________________________________________________________________

Your doctor's details

Doctor's name Full address ________________________________________________________________________
___________________________________________________________________________________

Phone number ________________________ Email ________________________________________

You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.
This report is valid for 6 months from the date the doctor and/or optician or optometrist signs it.
Please return it together with your application form.

Examining doctor's details - to be completed by the doctor carrying out the examination.

Doctor's name ________________________________________________________________________

Full address ________________________________________________________________________

Phone number ________________________ Email ________________________________________

GMC registration number ______________________________________________________________

You must sign and date this form in Section 10. All black outlined boxes MUST be answered. Please make sure all sections of the form have been completed. The form will be returned to you if you don't do this.
Medical examination report
Vision assessment
To be filled in by a doctor or optician/optometrist

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 (V) 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 (see INF4D). 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)
   □□□□□□□□□□□□□□□□□□□□

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 + (or) - 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 □

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? If Yes to any of questions 7-10, please give full details in the box provided.
   Yes □ No □

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)
□□□□□□□□□□□□□□□□□□□□

Signature of examining doctor/optician
□□□□□□□□□□□□□□□□□□□□

Date of signature □□□□□□□□□

Please provide your GOC, HPC or GMC number □□□□□□□□□

Doctor/optometrist/optician's stamp

Applicant's full name □□□□□□□□□□□□□□□□□□□□

Date of birth □□□□□□□□□

Please do not detach this page
# Medical examination report

## Medical assessment

- Please check the applicant’s identity before you proceed.
- Please ensure you fully examine the applicant and take the applicant’s history.

### 1. Neurological disorders

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Please tick ✓ the appropriate box(es)

- [ ] Is there a history of, or evidence of any neurological disorder?
- [ ] If No, go to section 2
- [ ] If Yes, please answer all the questions below, give details in section 6, page 6 and enclose relevant hospital notes.

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
     - Last attack
   - (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
   - (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 (a)-(e), please supply reports if available.

2. Stroke or TIA?
   - [ ] If Yes, please give date
   - [ ] Has there been a FULL recovery?
   - [ ] Has a carotid ultrasound been undertaken?
   - [ ] If Yes, was the carotid artery stenosis >50% in either carotid artery?
   - [ ] Has there been a carotid endarterectomy?

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?

11. Does the applicant suffer from narcolepsy?

### 2. Diabetes mellitus

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<th>Yes</th>
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- Does the applicant have diabetes mellitus? [ ]
  - If No, go to section 3, page 4
  - If Yes, please answer all the questions below.

1. Is the diabetes managed by:
   - (a) Insulin?
     - If Yes, please give date started on insulin
   - (b) If treated with insulin, are there at least 3 continuous 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 (no more than 2 hours before the start of the first journey and every 2 hours while 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 4-5 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.

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**Applicant’s full name**

**Date of birth**

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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 4c
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

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

2. Acute coronary syndrome including myocardial infarction? □ Yes □ No

If Yes, please give date

3. Coronary angioplasty (P.C.I.)? □ Yes □ No

If Yes, please give date of most recent intervention

4. Coronary artery by-pass graft surgery? □ Yes □ No

If Yes, please give date

5. If Yes to any of the above, are there any physical health problems (e.g. mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? □ Yes □ No

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 and enclose relevant hospital notes.

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?

If Yes:

(a) Please give date of implantation

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

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

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
<table>
<thead>
<tr>
<th>d</th>
<th>Valvular/congenital heart disease</th>
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<tbody>
<tr>
<td>Is there a history of, or evidence of, valvular/congenital heart disease?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>If No, go to section 4e</td>
<td></td>
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<tr>
<td>If Yes, please answer all questions below and give details in section 6 page 6 and enclose relevant hospital notes.</td>
<td>Yes  No</td>
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<tr>
<td>1. Is there a history of congenital heart disease?</td>
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<td>2. Is there a history of heart valve disease?</td>
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<tr>
<td>3. Is there a history of aortic stenosis?</td>
<td>Yes  No</td>
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<tr>
<td>If Yes, please provide relevant reports</td>
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<tr>
<td>4. Is there any history of embolism? (not pulmonary embolism)</td>
<td>Yes  No</td>
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<tr>
<td>5. Does the applicant currently have significant symptoms?</td>
<td>Yes  No</td>
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<tr>
<td>6. Has there been any progression since the last licence application? (if relevant)</td>
<td>Yes  No</td>
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<th>e</th>
<th>Cardiac other</th>
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<tr>
<td>Is there a history of, or evidence of heart failure?</td>
<td>Yes  No</td>
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<td>If No, go to section 4f</td>
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<td>If Yes, please answer all questions and enclose relevant hospital notes.</td>
<td>Yes  No</td>
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<tr>
<td>1. Established cardiomyopathy?</td>
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<td>2. Has a left ventricular assist device (LVAD) been implanted?</td>
<td>Yes  No</td>
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<tr>
<td>3. A heart or heart/lung transplant?</td>
<td>Yes  No</td>
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<td>4. Untreated atrial myxoma?</td>
<td>Yes  No</td>
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<th>Blood pressure</th>
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<td>If resting blood pressure is 180 mm/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.</td>
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<tr>
<td>1. Please record today's best resting blood pressure reading</td>
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<tr>
<td>2. Is the applicant on anti-hypertensive treatment?</td>
<td>Yes  No</td>
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<tr>
<td>If Yes, please provide three previous readings with dates if available</td>
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5 General

All questions must be answered. If Yes to any, give full details in section 6 and enclose relevant hospital notes.

1. 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 clinical issue. Please give details in section 6.

b) Please answer questions (i) – (vi) for all sleep conditions

(i) Date of diagnosis [ ] [ ] [ ] [ ] [ ] [ ] Yes No

(ii) Is it controlled successfully? Yes No

(iii) If Yes, please state treatment

(iv) Is applicant compliant with treatment? Yes No

(v) Please state period of control

(vi) Date of last review

2. Is there currently any functional impairment that is likely to affect control of the vehicle?

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?

5. Is the applicant profoundly deaf?

   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?

6. Does the applicant have a history of liver disease of any origin?

   If Yes, please give details in section 6

7. Is there a history of renal failure?

   If Yes, please give details in section 6

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

9. Does any medication currently taken cause the applicant side effects that could affect safe driving?

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

10. Does the applicant have any other medical condition that could affect safe driving?

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

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

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

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<tr>
<th>Medication</th>
<th>Dosage</th>
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Reason for taking:

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<th>Medication</th>
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Reason for taking:

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<th>Medication</th>
<th>Dosage</th>
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Reason for taking:

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

Examiner's details
To be completed by the doctor carrying out the examination.
Please ensure all sections of the form have been completed. The form will be returned to you if you do not do this.

I confirm that this report was completed by me at examination. I also confirm 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

Doctors stamp

Applicant's full name

Date of birth
This section MUST be filled in and must NOT be altered in any way.

Please read the following important information carefully then sign to confirm the statements below.

**Important information about Consent**

On occasion, as part of the investigation into your fitness to drive, the Taxi Licensing Authority may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical 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 the Taxi Licensing Authority. The membership of these panels conforms strictly to the principle of confidentiality.

**Consent and Declaration**

I authorise my Doctor(s) and Specialists(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Taxi Licensing Authority.

I authorise the Taxi Licensing Authority 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 licence to drive taxis and private hire vehicles and can lead to prosecution.

Name ______________________________________________________________________________

Signature________________________________________     Date _____________________________

I authorise Wiltshire Council to:

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<th>YES</th>
<th>NO</th>
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<tr>
<td>Inform my Doctor(s) of the outcome of my case</td>
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<tr>
<td>Release reports to my Doctor(s)</td>
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**Check List:**

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<th>YES</th>
<th>NO</th>
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<tr>
<td>Have you signed and dated the consent and declaration and drivers declaration on page 2 of form</td>
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<tr>
<td>Have you checked that the report has been fully completed by the optician/doctor</td>
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</table>

This report is valid for 6 months from the date the doctor and/or optician or optometrist signs it. Please return it together with your application form.
**Medical Examination GP Declaration**  
for a hackney carriage/private hire drivers licence  
(This form must be attached to the completed D4 Wiltshire medical form)  

To be completed by the GP carrying out the medical.

Medical Examination forms **will not** be accepted by the licensing authority for licensing purposes if this form has not been completed and attached to the D4 medical form, along with the HC/PH Driver Medical Fitness Declaration.

Failure to comply with the above will require the applicant to submit a further medical at a cost incurred by the applicant.

Please arrange for the patient to be examined.

**Please complete the medical examination report. You are advised to consult DVLA’s “At a Glance Guide to the current Medical Standards of Fitness to Drive” – Group 2 Entitlement. For further information, please refer to www.dft.gov.uk/dvla/medical/ataglance**

Applicants who may be symptom free at the time of the examination must be advised that if, in future, they develop symptoms of a condition which could affect safe driving and they hold a hackney carriage or private hire driver’s licence, they must inform the Licensing Officer at Wiltshire Council and the Driver’s medical Group at DVLA.

Please ensure that you have completed all the sections and that the surgery practice “stamp” has been used where indicated.

<table>
<thead>
<tr>
<th>Applicants Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telephone No:</strong></td>
<td></td>
</tr>
</tbody>
</table>

I have today examined the applicant for the purposes of establishing medical fitness to the DVLA Group 2 Entitlement. The medical form was signed in my presence by the applicant, and I have seen identification to verify their identity - passport/photo card driving licence/non – photo driving licence/ 2 proofs of address; In making this decision I have consulted the DVLA “At a Glance Guide to the current Medical Standards of Fitness to Drive”, and consider that the applicant:

<table>
<thead>
<tr>
<th>Is fit to drive a licensed vehicle</th>
<th>Is not fit to drive a licensed vehicle</th>
</tr>
</thead>
</table>

If the applicant is under 65 years of age, do they have any medical condition that would require yearly monitoring under the DVLA’s Group 2 Entitlement?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If answered **Yes**, please advise medical condition

<table>
<thead>
<tr>
<th>Signature of Medical Practitioner</th>
<th>Date:</th>
</tr>
</thead>
</table>