

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 doctor to have your medical carried out.
- 2. You must complete the HC/PH Driver Medical Fitness Declaration found overleaf on page 2. and the top part of page 3 prior to attending your appointment and then sign applicant consent and declaration on page 10 once your appointment has been completed.
- 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 doctor 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 **Highway Operations** Wiltshire Council County Hall Bythesea Road Trowbridge

Wiltshire

BA14 8JN Email: fleet.licensing@wiltshire.gov.uk Tel: 01225 770271

Hackney Carriage/Private Hire Driver Medical Fitness Declaration

Please advise if you have any of the following health issues:	Yes	No
Epilepsy, Fits or blackouts		
Repeated attacks of sudden disabling giddiness (dizziness that prevents you from	1	
functioning normally)		
Diabetes controlled by insulin		
Diabetes controlled by tablets		
An implanted cardiac pacemaker and / or An implanted cardiac defibrillator (ICD)		
Persistent alcohol and / or drug abuse or dependency		
Parkinson's disease		
Narcolepsy or sleep apnoea syndrome		
Stroke, with any symptoms lasting longer than one month, including recurrent 'mini		
strokes' or TIAs (Transient Ischaemic Attacks)		
Any type of brain surgery, severe head injury involving inpatient treatment, or brain		
tumour		
Any other chronic (long term) neurological condition		
A serious problem with memory or episodes of confusion		
Severe learning disability		
Serious psychiatric illness or mental ill-health		
Total loss of sight in one eye		
Any condition affecting both eyes, or the remaining eye only (not including short or		
long sight or colour blindness)		
Any condition affecting your visual field (the surrounding area you can see when		
looking directly ahead)		
Visual problems affecting either eye		
Any persistent limb problem for which your driving has to be restricted to certain types		
of vehicles or those with adapted controls		
Angina, other heart conditions or heart operation		
Any other condition that may affect driving. Please provide details below:		

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.

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:	

Medical Examination Form for a hackney carriage/private hire drivers licence

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

The is also available at www.gov. altitlegpty arriving license mealed containen
Your details (applicant)
Name
Full address
Daytime phone number
Email address
Your doctor's details
Doctor's name Full address
Phone number Email
Please ensure you complete page 2 and 3 (above) prior to your medical being completed. You must sign and date the declaration on page 10 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.
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
Please make sure all both yourself and the applicant have fully completed all sections of the form including the doctor declaration on page 11. If a separate vision assessment is being carried out page 4 must be fully completed prior to the medical examination being carried out. The form will be returned if not fully completed.

Vision assessment

To be filled in by an optician, optometrist or doctor (if being completed by optician or optometrist this page must be fully completed prior to full medical examination being carried out)

Ар	plicant's full name Please do not	detacl	Date of birth DDMMYY
4.	Is there diplopia? (a) Is it controlled? Please indicate below and give full details in Q7. Patch or Glasses Other glasses with frosted glass prism prism provide details)	Pleas	of signature se provide your GOC or GMC number or, optometrist or optician's stamp
3.	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If Yes, please give full details below. If formal visual field testing is considered necessary, DVLA will commission this at a later date.	I cor exan	e of examining doctor or optician undertaking firm that this report was completed by me at mination and the applicant's history has been taken consideration.
	If No, go to Q3. If Yes, please provide the visual acuities using the correction worn for driving. R (c) What kind of corrective lenses are worn to meet this standard? Glasses Contact lenses Both together (d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? (e) If correction is worn for driving, is it well tolerated? If No, please give full details in Q7.	7.	If Yes, please give full details in Q7 below. Details or additional information
2.	The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other. (a) Please provide uncorrected visual acuities for each eye. R L Yes No (b) Are corrective lenses worn for driving?	6.	in Q7 below. (a) Intolerance to glare (causing incapacity rather than discomfort) and/or (b) Impaired contrast sensitivity and/or (c) Impaired twilight vision Does the applicant have any other ophthalmic condition? Yes No
1.	Please confirm () the scale you are using to express the applicant's visual acuities. Shellen Shellen expressed as a decimal LogMAR		Does the applicant on questioning report symptoms of any of the following that impairs their ability to drive? Please indicate below and give full details



Medical examination report

Medical assessment

Must be filled in by a doctor

1	Neurological disorders		2	Diabetes mellitus		
Is the discourt of No.	rise tick ✓ the appropriate boxes ere a history or evidence of any neurological rder (see conditions in questions 1 to 11 below)? Do, go to section 2, Diabetes mellitus es, please answer all questions below and enclose relevant on the control of	No /ant	If No	s the applicant have diabetes mellitus? o, go to section 3, Cardiac es, please answer all questions below. Is the diabetes managed by:	Yes	No
1.	Has the applicant had any form of seizure? (a) Has the applicant had more than one attack? (b) If Yes, 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 the medication section 8, page 6. (d) If no longer treated, when did treatment end? (e) Has the applicant had a brain scan? If Yes, please give details in section 9, page 7. (f) Has the applicant had an EEG? If you have answered Yes to any of above, you must supply medical reports.	No	2.	 (a) Insulin? If No, go to 1c If Yes, please give date started on insulin. (b) Are there at least 3 continuous months of blood glucose readings stored on a memory meter(s)? If No, please give details in section 9, page (c) Other injectable treatments? (d) A Sulphonylurea or a Glinide? (e) Oral hypoglycaemic agents and diet? If Yes to any of (a) to (e), please fill in the medication section 8, page 6. (f) Diet only? (a) Does the applicant test blood glucose at least twice every day? (b) Does the applicant test at times relevant 		No
2.	Has the applicant had an episode(s) of non-epileptic attack disorder? (a) If Yes, please give date of most recent episode. (b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	No		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.	Stroke or TIA? If Yes, give date. (a) Has there been a full recovery?	No .	3.	Is there full awareness of hypoglycaemia?	Yes	No
4.	(b) Has a carotid ultra sound been undertaken? (c) If Yes, was the carotid artery stenosis >50% in either carotid artery? (d) Is there a history of multiple strokes/TIAs? Sudden and disabling dizziness or vertigo within the last year with a liability to recur?		4.	Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If Yes, please give details and dates below.	Yes	No
5.	Subarachnoid haemorrhage?		_		Yes	No
6.	Serious traumatic brain injury within the last 10 years?		5.	Is there evidence of: (a) Loss of visual field? (b) Severe peripheral neuropathy, sufficient		
7.	Any form of brain tumour?			to impair limb function for safe driving?	Ш	Ш
8.	Other brain surgery or abnormality?			If Yes, please give details in section 9, page 7.		
9.	Chronic neurological disorders?		6.	Has there been laser treatment or intra-vitreal treatment for retinopathy?	Yes	No
10.	Parkinson's disease? Blackout or impaired consciousness within the last 10 years?			If Yes, please give most recent date of treatment.		_
Ap	plicant's full name		-	Date of birth	l V	V

3 Cardiac		c Peripheral arterial disease (excluding Buerger's disease)
a Coronary artery disease		aortic aneurysm/dissection
Is there a history or evidence of coronary artery disease? If No, go to section 3b, Cardiac arrhythmia If Yes, please answer all questions below and enclose relevant hospital notes.	Yes No	Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? If No, go to section 3d, Valvular/congenital heart disease If Yes, please answer all questions below and enclose relevant hospital notes.
Has the applicant suffered from angina? If Yes, please give the date of the last known attack.	Yes No	1. Peripheral arterial disease? Yes No (excluding Buerger's disease)
2. Acute coronary syndrome including myocardial infarction? If Yes, please give date.	Yes No	Yes No 2. Does the applicant have claudication? If Yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?
3. Coronary angioplasty (PCI)? If Yes, please give date of most recent intervention.	Yes No	3. Aortic aneurysm?
4. Coronary artery bypass graft surgery? If Yes, please give date.	Yes No	(a) Site of aneurysm: Abdominal (b) Has it been repaired successfully? (c) Please provide latest transverse aortic diameter measurement and date obtained
5. If Yes to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would mak the applicant unable to undertake 9 minutes of standard Bruce Protocol ETT? Please give deta	the	using measurement and date boxes.
		4. Dissection of the aorta repaired successfully? Yes No If Yes, please provide copies of all reports including those dealing with any surgical treatment.
b Cardiac arrhythmia		5. Is there a history of Marfan's disease? Yes No If Yes, please provide relevant hospital notes.
Is there a history or evidence of cardiac arrhythmia?	Yes No	d Valvular/congenital heart disease
If No, go to section 3c, Peripheral arterial disease of Yes, please answer all questions below and encrelevant hospital notes.		Is there a history or evidence of valvular or congenital heart disease? If No, go to section 3e, Cardiac other
1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect,	Yes No	If Yes, answer all questions below and provide relevant hospital notes.
atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?	Vaa Na	Yes No 1. Is there a history of congenital heart disease?
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? 2. Has an ICD (Instituted Conding Perfibrillator).	Yes No	2. Is there a history of heart valve disease? Yes No
3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?	Yes No	3. Is there a history of aortic stenosis? If Yes, please provide relevant reports (including echocardiogram).
4. Has a pacemaker or a biventricular pacemaker/cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted?	Yes No	4. Is there any history of embolism? Yes No (not pulmonary embolism)
If Yes: (a) Please give date of implantation.		5. Does the applicant currently have significant symptoms?
(b) Is the applicant free of the symptoms that caused the device to be fitted?(c) Does the applicant attend a pacemaker clinic regularly?		6. Has there been any progression since the last licence application (if relevant)?

e Cardiac other			boxes provided, give details in section 9, page 7 and provide
Is there a history or evidence of heart failure? If No go to section 3f, Cardiac channelopathies If Yes, please answer all questions and enclose relevant hospital notes.	Yes	No	relevant reports. 2. Has an exercise ECG been undertaken (or planned)? 2. Has an exercise ECG been undertaken (or planned)?
Please provide the NYHA class, if known.	Vas	Na	3. Has an echocardiogram been undertaken (or planned)?
2. Established cardiomyopathy? If Yes, please give details in section 9, page 7.	Yes		(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	Yes		4. Has a coronary angiogram been undertaken Yes No (or planned)?
4. A heart or heart/lung transplant?			5. Has a 24 hour ECG tape been undertaken Yes No
5. Untreated atrial myxoma?	Yes	NO	(or planned)?
f Cardiac channelopathies Is there a history or evidence of the	Yes	No	6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?
following conditions? If No, go to section 3g, Blood pressure			7. Date last seen by a consultant specialist for any cardiac
1. Brugada syndrome?	Yes	No	condition declared:
2. Long QT syndrome? If Yes to either, please give details in section 9,	Yes	No	4 Psychiatric illness
page 7 and enclose relevant hospital notes. g Blood pressure			Is there a history or evidence of psychiatric illness within the last 3 years? If No, go to section 5, Substance misuse if Yes, please answer all questions below.
All questions must be answered. If resting blood pressure is 180 mm/Hg systolic or and/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the of the 3 readings in the box provided. 1. Please record today's best	furthe	er	 Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition. Psychosis or hypomania/mania within the past 12 months, including psychotic depression?
resting blood pressure reading. 2. Is the applicant on anti-hypertensive treatment? If Yes, please provide three previous readings with dates if available.	Yes	No	Yes No 3. Dementia or cognitive impairment? 5 Substance misuse
	Y)		Is there a history of drug/alcohol misuse or dependence? If No, go to section 6, Sleep disorders If Yes, please answer all questions below.
3. Is there a history of malignant hypertension? If Yes, please give details in section 9, page 7 (including date of diagnosis and any treatr	Yes ment e		1. Is there a history of alcohol dependence in the past 6 years?(a) Is it controlled?(b) Has the applicant undergone an alcohol
h Cardiac investigations	Yes	No	detoxification programme? If Yes, give date started:
Have any cardiac investigations been undertaken or planned? If No, go to section 4, Psychiatric illness If Yes, please answer questions 1 to 7.			2. Persistent alcohol misuse in the past 3 years? (a) Is it controlled?
1. Has a resting ECG been undertaken? 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 in section 9.	Yes		3. Persistent misuse of drugs or other substances in the past 6 years? (a) If Yes, the type of substance misused? (b) Is it controlled? (c) Has the applicant undertaken an opiate treatment programme? If Yes, give date started
Applicant's full name		\blacksquare	Date of birth

6	Sleep disorders	5. Does the applicant have a history of liver disease of any origin?					
1.	Is there a history or evidence of Obstructive Yes No Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? If No, go to section 7, Other medical conditions.	If Yes, is this the result of alcohol misuse? If Yes, please give details in section 9, page 7.					
	If Yes, please give diagnosis and answer all questions below.	6. Is there a history of renal failure? If Yes, please give details in section 9, page 7.					
	a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:	7. Does the applicant have severe symptomatic Yes No respiratory disease causing chronic hypoxia?					
	Mild (AHI <15) Moderate (AHI 15 - 29) Severe (AHI >29) Not known If another measurement other than AHI is used, it	8. Does any medication currently taken cause the applicant side effects that could affect safe driving? If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.					
	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 9 page 7, Further details.	9. Does the applicant have any other medical Yes No condition that could affect safe driving? If Yes, please provide details in section 9, page 7.					
	 Please answer questions (i) to (vi) for all sleep conditions. 	8 Medication					
	(i) Date of diagnosis: Yes No	Please provide details of all current medication including					
	(ii) Is it controlled successfully? (iii) If Yes, please state treatment.	eye drops (continue on a separate sheet if necessary).					
		Medication Dosage					
	Yes No	Reason for taking:					
	(iv) Is applicant compliant with treatment?(v) Please state period of control:	Date started:					
	years months (vi) Date of last review.	Medication Dosage					
2.	Is there a history or evidence of narcolepsy? Yes No	Reason for taking: Date started:					
7	Other medical conditions	Medication Dosage					
1.	Is there currently any functional impairment that is likely to affect control of the vehicle?	Reason for taking: Date started:					
2.	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	Medication Dosage					
3.	Is there any illness that may cause significant Yes No fatigue or cachexia that affects safe driving?	Reason for taking: Date started:					
4.	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?	Medication Dosage					
		Reason for taking: Date started:					
Ap	plicant's full name	Date of birth					

9 Further details	10 Consultants' details
Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the	Please provide details of type of specialists or consultants, including address.
space below to provide any additional information.	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment.
	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	If more consultants seen give details on a separate sheet.
	11 Examining doctor's signature and stamp
	To be completed by the doctor carrying out the examination.
	Please make sure 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 and I have taken the applicant's history into account. 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 the UK.
	Signature of examining doctor
	Date of signature
	Doctor's stamp
Applicant's full name	Date of birth

This page must be completed by the applicant Applicant's consent and declaration

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:-	YES	NO
Inform my Doctor(s) of the outcome of my case		
Release reports to my Doctor(s)		
Check List:	YES	NO
Have you signed and dated the consent and declaration and on page 2 of form	drivers declaration	
Have you checked that the report has been fully completed b optician/doctor	by the	

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 Doctor 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 Doctor 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.

Applicants Name:					Date of Birth:				
Telephone No:									
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:									
Is FIT to drive a lice vehicle									
If the applicant is under 65 years of age, d condition that would require yearly monitor Entitlement?						ıp 2	Yes		No
If answered Yes , please advise medical condition									
Signature of Docto	r					Date):		