Wiltshire Council
Where everybody matters

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 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:	Yes	No
Epilepsy, Fits or blackouts		
Repeated attacks of sudden disabling giddiness (dizziness that prevents you from 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

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)

1. Please confirm (✓) the scale you are using to express the applicant's visual acuities.

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

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 ☐

(b) Are corrective lenses worn for driving? Yes ☐ No ☐

If No, go to Q3.

If Yes, please provide the visual acuities using the correction worn for driving.

R ☐ L ☐

(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? Yes ☐ No ☐

(e) If correction is worn for driving, is it well tolerated? Yes ☐ No ☐

If No, please give full details in Q7.

3. 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 Yes, please give full details below.

If formal visual field testing is considered necessary, DVLA will commission this at a later date.

4. Is there diplopia? Yes ☐ No ☐

(a) Is it controlled? ☐ ☐

Please indicate below and give full details in Q7.

Patch or glasses with frosted glass ☐ Glasses with/without prism ☐ Other (if other please provide details) ☐

5. Does the applicant on questioning report symptoms of any of the following that impairs their ability to drive? Yes ☐ No ☐

Please indicate below and give full details in Q7 below.

(a) Intolerance to glare (causing incapacity rather than discomfort) and/or ☐

(b) Impaired contrast sensitivity and/or ☐

(c) Impaired twilight vision ☐

6. Does the applicant have any other ophthalmic condition? Yes ☐ No ☐

If Yes, please give full details in Q7 below.

7. Details or additional information

Name of examining doctor or optician undertaking

I confirm that this report was completed by me at examination and the applicant's history has been taken into consideration.

Date of signature D D M M Y Y

Please provide your GOC or GMC number

Doctor, optometrist or optician's stamp

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

Please do not detach this page

Medical examination report

Medical assessment

Must be filled in by a doctor

1 Neurological disorders

Please tick ✓ the appropriate boxes

Is there a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? Yes ☐ No ☐

If No, go to section 2, Diabetes mellitus

If Yes, please answer all questions below and enclose relevant hospital notes.

	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 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 the medication section 8, page 6.	☐	☐
(d) If no longer treated, when did treatment end? D D M M Y Y		
(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.	☐	☐
2. Has the applicant had an episode(s) of non-epileptic attack disorder?	☐	☐
(a) If Yes, please give date of most recent episode. D D M M Y Y		
(b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	☐	☐
3. Stroke or TIA?	☐	☐
If Yes, give date. D D M M Y Y		
(a) Has there been a **full** recovery?	☐	☐
(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?	☐	☐
4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?	☐	☐
5. Subarachnoid haemorrhage?	☐	☐
6. Serious traumatic brain injury within the last 10 years?	☐	☐
7. Any form of brain tumour?	☐	☐
8. Other brain surgery or abnormality?	☐	☐
9. Chronic neurological disorders?	☐	☐
10. Parkinson's disease?	☐	☐
11. Blackout or impaired consciousness within the last 10 years?	☐	☐

2 Diabetes mellitus

Does the applicant have diabetes mellitus? Yes ☐ No ☐

If No, go to section 3, Cardiac

If Yes, please answer all questions below.

	Yes	No
1. Is the diabetes managed by:		
(a) Insulin? If No, go to 1c	☐	☐
If Yes, please give date started on insulin. D D M M Y Y		
(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 7.	☐	☐
(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?	☐	☐
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 full awareness of hypoglycaemia?	☐	☐
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.	☐	☐
5. Is there evidence of:		
(a) Loss of visual field?	☐	☐
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? If Yes, please give details in section 9, page 7.	☐	☐
6. Has there been laser treatment or intra-vitreal treatment for retinopathy? If Yes, please give most recent date of treatment. D D M M Y Y	☐	☐

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

3 Cardiac

a Coronary artery disease

Is there a history or evidence of coronary artery disease? Yes ☐ No ☐

If No, go to section 3b, Cardiac arrhythmia

If Yes, please answer all questions below 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 (PCI)? Yes ☐ No ☐

If Yes, please give date of most recent intervention. D D M M Y Y

4. Coronary artery bypass graft surgery? Yes ☐ No ☐

If Yes, please give date. D D M M Y Y

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

b Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia? Yes ☐ No ☐

If No, go to section 3c, Peripheral arterial disease

If Yes, please answer all questions below and enclose relevant hospital notes.

1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or 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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes ☐ No ☐

4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes ☐ No ☐

If Yes:

(a) Please give 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 or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? Yes ☐ No ☐

If No, go to section 3d, Valvular/congenital heart disease

If Yes, please answer all questions below and enclose relevant hospital notes.

1. Peripheral arterial disease? (excluding Buerger's disease) Yes ☐ No ☐

2. Does the applicant have claudication? Yes ☐ No ☐

If Yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT? ☐ ☐

3. Aortic aneurysm? Yes ☐ No ☐

If Yes:

(a) Site of aneurysm: Thoracic ☐ Abdominal ☐

(b) Has it been repaired successfully? ☐ ☐

(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.

☐.☐ cm D D M M Y Y

4. Dissection of the aorta repaired successfully? Yes ☐ No ☐

If Yes, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? Yes ☐ No ☐

If Yes, please provide relevant hospital notes.

d Valvular/congenital heart disease

Is there a history or evidence of valvular or congenital heart disease? Yes ☐ No ☐

If No, go to section 3e, Cardiac other

If Yes, answer all questions below and provide relevant hospital notes.

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 (including echocardiogram).

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 ☐

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

e Cardiac other

Is there a history or evidence of heart failure? Yes ☐ No ☐
If No go to section 3f, Cardiac channelopathies
If Yes, please answer all questions and enclose relevant hospital notes.

1. Please provide the NYHA class, if known.

2. Established cardiomyopathy? Yes ☐ No ☐
If Yes, please give details in section 9, page 7.

3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes ☐ No ☐

4. A heart or heart/lung transplant? Yes ☐ No ☐

5. Untreated atrial myxoma? Yes ☐ No ☐

f Cardiac channelopathies

Is there a history or evidence of the following conditions? Yes ☐ No ☐
If No, go to section 3g, Blood pressure

1. Brugada syndrome? Yes ☐ No ☐

2. Long QT syndrome? Yes ☐ No ☐
If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.

g Blood pressure

All questions must be answered.
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.

1. Please record today's best resting 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

3. Is there a history of malignant hypertension? Yes ☐ No ☐
If Yes, please give details in section 9, page 7 (including date of diagnosis and any treatment etc).

h Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes ☐ No ☐
If No, go to section 4, Psychiatric illness
If Yes, please answer questions 1 to 7.

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 in section 9, page 7.

Note: If Yes to questions 2 to 6, please give dates in the boxes provided, give details in section 9, page 7 and provide relevant reports.

2. Has an exercise ECG been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐

3. Has an echocardiogram been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐
(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%? ☐ ☐

4. Has a coronary angiogram been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐

5. Has a 24 hour ECG tape been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐

7. Date last seen by a ~~consultant specialist for~~ any cardiac condition declared: D D M M Y Y

4 Psychiatric illness

Is there a history or evidence of psychiatric illness within the last 3 years? Yes ☐ No ☐
If No, go to section 5, Substance misuse
If Yes, please answer all questions below.

1. Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition. Yes ☐ No ☐

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes ☐ No ☐

3. Dementia or cognitive impairment? Yes ☐ No ☐

5 Substance misuse

Is there a history of drug/alcohol misuse or dependence? Yes ☐ No ☐
If No, go to section 6, Sleep disorders
If Yes, please answer all questions below.

1. Is there a history of alcohol dependence in the past 6 years? Yes ☐ No ☐
(a) Is it controlled? ☐ ☐
(b) Has the applicant undergone an alcohol detoxification programme? ☐ ☐
If Yes, give date started: D D M M Y Y

2. Persistent alcohol misuse in the past 3 years? Yes ☐ No ☐
(a) Is it controlled? ☐ ☐

3. Persistent misuse of drugs or other substances in the past 6 years? Yes ☐ No ☐
(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 D D M M Y Y

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

6 Sleep disorders

1. Is there a history or evidence of Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? Yes ☐ No ☐

If No, go to section 7, Other medical conditions.
If Yes, please give diagnosis and answer all questions below.

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 9 page 7, Further details.

b) Please answer questions (i) to (vi) for **all** sleep conditions.

(i) Date of diagnosis: D D M M Y Y

(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:

years ____ months ____

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

2. Is there a history or evidence of narcolepsy? Yes ☐ No ☐

7 Other medical conditions

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? Yes ☐ No ☐

5. Does the applicant have a history of liver disease of any origin? Yes ☐ No ☐

If Yes, is this the result of alcohol misuse? Yes ☐ No ☐

If Yes, please give details in section 9, page 7.

6. Is there a history of renal failure? Yes ☐ No ☐

If Yes, please give details in section 9, page 7.

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes ☐ No ☐

8. Does any medication currently taken cause the applicant side effects that could affect safe driving? Yes ☐ No ☐

If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.

9. Does the applicant have any other medical condition that could affect safe driving? Yes ☐ No ☐

If Yes, please provide details in section 9, page 7.

8 Medication

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

Medication	Dosage
Reason for taking:	
Date started: D D M M Y Y	

Medication	Dosage
Reason for taking:	
Date started: D D M M Y Y	

Medication	Dosage
Reason for taking:	
Date started: D D M M Y Y	

Medication	Dosage
Reason for taking:	
Date started: D D M M Y Y	

Medication	Dosage
Reason for taking:	
Date started: D D M M Y Y	

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

9 Further details

Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the space below to provide any additional information.

10 Consultants' details

Please provide details of type of specialists or consultants, including address.

Consultant in

Reason for attendance

Name

Address

Date of last appointment. D D M M Y Y

Consultant in

Reason for attendance

Name

Address

Date of last appointment: D D M M Y Y

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 D D M M Y Y

Doctor's 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

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 drivers declaration on page 2 of form		
Have you checked that the report has been fully completed by the optician/doctor		

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.

<table>
<tr><td>Applicants Name:</td><td colspan="2"></td><td>Date of Birth:</td><td></td></tr>
<tr><td>Telephone No:</td><td colspan="4"></td></tr>
<tr><td colspan="5">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:</td></tr>
<tr><td colspan="2">Is FIT to drive a licensed vehicle</td><td></td><td colspan="2">Is NOT FIT to drive a licensed vehicle</td></tr>
<tr><td colspan="3">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?</td><td>Yes</td><td>No</td></tr>
<tr><td colspan="2">If answered Yes, please advise medical condition</td><td colspan="3"></td></tr>
<tr><td>Signature of Doctor</td><td colspan="2"></td><td>Date:</td><td></td></tr>
</table>