***STRATEGIC DIRECTOR, ECONOMY & ENVIRONMENT /***

***CYFARWYDDWR STRATEGOL, ECONOMI A’R AMGYLCHEDD Rachel Jowitt***

**MEDICAL REPORT FOR A HACKNEY CARRIAGE AND PRIVATE HIRE VEHICLE DRIVER’S LICENCE**

**LOCAL GOVERNMENT (MISCELLANEOUS PROVISIONS) ACT 1976**

**Notes for the Applicant**

**Medical reports are only acceptable if the medical examination has been conducted by your own doctor or a doctor who has access to your medical history. Reports from other sources will not be accepted.**

**Applicants** must return the completed medical to the licensing section within 4 months of the issue date.

The applicant must pay the medical practitioner’s fee, unless other arrangements have been made. The licensing authority accepts no liability to pay it.

**Notes for the completing doctor**

## Please read these notes before examining the applicant

Please ensure you have the applicant’s full medical records and not just a summary. If you do not have this information, please postpone the appointment.

The completed and signed form should be given to the applicant who will forward it to the licensing authority. Please include the surgery’s stamp at the bottom of each page and also on the last page of the form, where requested.

The medical fitness standard adopted by the licensing authority for such licence holders reflects the fitness standard for **Group 2 DVLA** drivers. This is a higher standard than that required by ordinary car drivers. Guidance can be found here:

<https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals>

Please provide as much detail as possible and where specific medical investigations have taken place (e.g. exercise cardiac testing, echocardiography, EEG) or where relevant specialist reports (e.g. outpatient or discharge reports) are available then copies of these should accompany the application form. Failure to do so may delay the application process.

# MEDICAL EXAMINATION FORM – BADGE NO. CD \_ \_ \_ \_

**Applicant Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | **D.O.B.** |  |
|  |  |  |  |
| **Address** |  |

## To be completed by the doctor

### SECTION 1: VISION

|  |  |  |
| --- | --- | --- |
| (a) | Is the visual acuity (corrective lenses may be worn) **at least** 6/12 as measured by the Snellen chart with both eyes open, or in the only eye if monocular? | YES / NO |
| (b) | Is the visual acuity (corrective lenses may be worn) **at least** 6/7.5 in the better eye AND **at least** 6/60 in the poorer eye, as measured by the Snellen chart? | YES / NO |
| (c) | Do corrective lenses have to be worn to achieve this standard? | YES / NO |
|  | If YES, are they well tolerated? | YES / NO |
|  | If glasses (not contact lenses) have to be worn to meet the above minimum standards, do they have a corrective power exceeding +8 dioptres in any meridian of either lens? | YES / NO |
|  | Please state all the visual acuities for all applicants: UNCORRECTED CORRECTED (if applicable)  Right Left Right Left*Note - Snellen readings with a (+) or (-) are not acceptable* |
|  | If there is NO perception of light in one eye, on what date did the applicant become monocular or lose the sight in one eye? |  |
| ……………………………………………………………...….………………………..……… |
| (f) | Is there a full binocular field of vision? (central and/or peripheral) | YES / NO |
| (g) | 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 details in SECTION 7) |
| (h) | Is there insuperable diplopia? *Note - Patching is not acceptable for licensing* | YES / NO(If YES, please give details in SECTION 7) |
| (i) | Does the applicant have any other ophthalmic condition? | YES / NO(If YES, please give details in SECTION 7) |

### SECTION 2: NERVOUS SYSTEM

|  |  |  |
| --- | --- | --- |
| (a) | Has the applicant had major or minor epileptic seizure(s)?   | YES / NO If YES,* 1. Please give details of last seizure

………………………...…………* 1. Please give date when treatment ceased …………………………………
 |
| (b) | Is there a history of blackouts/ impaired consciousness within the past 5 years?  | YES / NO  |
| (c) | Is there a history of stroke or TIA within the past 5 years?  | YES / NO |
| (d) | Is there a history of sudden disabling dizziness or vertigo with the last year?  | YES / NO |
| (e) | Is there a history of chronic and/or progressive neurological disorder? | YES / NO(If YES, please give details in SECTION 7) |
| (f) | Is there a history of brain surgery?  | YES / NO(If YES, please give details in SECTION 7) |
| (g) | Is there a history of serious head injury?  | YES / NO(If YES, please give details in SECTION 7)  |
| (h) | Is there a history of brain tumour, benign or malignant, primary or secondary?  | YES / NO(If YES, please give details in SECTION 7) |

**SECTION 3: DIABETES MELLITUS**

|  |  |  |
| --- | --- | --- |
| (a) | Does the applicant have diabetes mellitus?  | YES / NO |
| **If YES, please answer questions (b)-(i) below. If NO, proceed to SECTION 4**. |
| (b) | Is the diabetes managed by:  |  |
| * 1. Insulin?
 | YES / NOIf YES, what date was insulin started ………………………………………….* *Separate questionnaire will need to be completed regarding insulin-treated diabetes.*
 |
| * 1. Oral hypoglycaemic agents and diet?
 | YES / NO |
| * 1. Diet only?
 | YES / NO |
| (c) | Is the diabetic control generally satisfactory?  | YES / NO |
| (d) | Is there evidence of loss of visual field?  | YES / NO |
| (e) | Has there been bilateral laser treatment?  | YES / NO If YES, please give date ….………………………………………….. |
| (f) | Is there evidence of severe peripheral neuropathy?  | YES / NO |
| (g) | Is there evidence of significant impairment of limb function or joint position sense? | YES / NO |
| (h) | Is there evidence of significant episodes of hypoglycaemia?  | YES / NO |
| (i) | Is there evidence of complete loss of warning symptoms of hypoglycaemia?  | YES / NO |

### SECTION 4: PSYCHIATRIC ILLNESS

|  |  |  |
| --- | --- | --- |
| (a) | Has the applicant suffered from or required treatment for a psychosis in the past 3 years?  | YES / NO (If YES, please give details in SECTION 7) |
| (b) | Has the applicant required treatment for any other psychiatric disorder within the past 6 months?  | YES / NO (If YES, please give details in SECTION 7) |
| (c) | Is there confirmed evidence of dementia?  | YES / NO |
| (d) | Any history of alcohol misuse or alcohol dependency in the past 3 years?  | YES / NO (If YES, please give details in SECTION 7)  |
| (e) | Any history of illicit drug/substance use / dependency in the past 3 years?  | YES / NO (If YES, please give details in SECTION 7) |

### SECTION 5: GENERAL

|  |  |  |
| --- | --- | --- |
| (a) | Does the applicant CURRENTLY have a significant disability of the spine or limbs which is likely to impair control of the vehicle?  | YES / NO (If YES, please give details in SECTION 7) |
| (b) | Is there a history of bronchogenic or other malignant tumour with a significant liability to metastasise cerebrally?  | YES / NO (If YES, please give dates and diagnosis and state whether there is current evidence of dissemination in SECTION 7) |
| (c) | Is the applicant profoundly deaf?  | YES / NO  |  |
| If YES, could this be overcome by any means to allow a telephone to be used in an emergency? | YES / NO |

**SECTION 6: CARDIAC**

|  |  |  |
| --- | --- | --- |
| **A.** | **Coronary Artery Disease** |  |
| (a) | Please indicate if there is a history of: |  |
| 1. Myocardial infarction?
 | YES / NOIf YES, please give date(s):……………………………………………………………………………………………… |
| 1. Coronary artery by-pass graft?
 | YES / NOIf YES, please give date(s):……………………………………………………………………………………………… |
| 1. Coronary angioplasty?
 | YES / NOIf YES, please give date(s):……………………………………………………………………………………………… |
| 1. Any other coronary artery procedures?
 | YES / NO (If YES, please give details in SECTION 7) |
| (b) | Has the applicant suffered from angina?  | YES / NO |  |
| If YES, is the applicant STILL suffering from angina or remaining angina free only by use of medication?  | YES / NO |
| (c) | Has the applicant suffered from heart failure?  | YES / NO |  |
| If YES, is the applicant STILL suffering from heart failure or only remains controlled by medication? | YES / NO |
| **If the answer to any questions in SECTION 6 A(a)-(c) above is YES, please answer questions (d)-(f) below. If the answer to all questions in Section 6 A(a)-(c) is NO, please proceed to SECTION 6 B below.** |
| (d) | Has a resting ECG been undertaken?  | YES / NOIf YES, please give date(s):……………………………………………………………………………………………… |
| Does it show pathological Q waves? | YES / NO |
| Does it show left bundle branch block?  | YES / NO |
| (e) | Has an exercise ECG been undertaken (or planned)? | YES / NO(If YES, please give date and provide details in SECTION 7) |
| (f) | Has an angiogram been undertaken?  | YES / NO(If YES, please give date and provide details in SECTION 7) |

|  |  |  |
| --- | --- | --- |
| **B.** | **Cardiac Arrhythmia** |  |
| (a) | Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years?  | YES / NO(If YES, please give details in SECTION 7) |
| **If YES, please answer questions (b)-(f) below. If NO, proceed to SECTION 6 C, below**. |
| (b) | Has the arrhythmia (or its medication) caused symptoms of sudden dizziness or impairment of consciousness or any symptom likely to distract attention during driving within the past 2 years?  | YES / NO(If YES, please give details in SECTION 7) |
| (c) | Has echocardiography been undertaken?  | YES / NO(If YES, please give date and provide details in SECTION 7) |
| (d) | Has an exercise test been undertaken?  | YES / NO(If YES, please give date and provide details in SECTION 7) |
| (e) | Has a pacemaker been implanted? | YES / NOIf YES, |  |
| Was it implanted to prevent bradycardia? | YES / NO |
| Is the applicant now free of sudden and/or disabling symptoms?  | YES / NO |
| Does the applicant attend a pacemaker clinic regularly? | YES / NO |
| (f) | Has a cardiac defibrillator been implanted or anti-ventricular tachycardia device been fitted?  | YES / NO |

|  |  |  |
| --- | --- | --- |
| **C.** | **Other Vascular Disorders**  |  |
| (a) | Is there a history of aortic aneurysm with a transverse diameter of 5cm or more (thoracic or abdominal)?  | YES / NO |  |
| If YES, has the aneurysm been successfully repaired?  | YES / NO |
| (b) | Is there symptomatic peripheral arterial disease? | YES / NO(If YES, please give details in SECTION 7) |
| (c) | Has there been dissection of the aorta | YES / NO(If YES, please give details in SECTION 7) |

|  |  |  |
| --- | --- | --- |
| **D.** | **Blood Pressure** |  |
| (a) | Is there a history of hypertension with BP reading consistently greater than 180 systolic or 100 diastolic?  | YES / NO |  |
| If YES, please supply most recent reading with dates……………………………………………..……………………………………………..……………………………………………..…………………………………………….. |
| If treated, does the medication cause any side effects likely to affect safe driving? | YES / NO |

|  |  |  |
| --- | --- | --- |
| **E.** | **Valvular Heart Disease**  |  |
| (a) | Is there history of valvular heart disease, with or without surgery?  | YES / NO(If YES, please give details in SECTION 7) |
| (b) | Is there any history of embolism?  | YES / NO(If YES, please provide details in SECTION 7) |
| (c) | Is there any history of arrhythmia – intermittent or persistent?  | YES / NO(If YES, please provide details in SECTION 7) |
| (d) | Is there any persistent dilatation or hypertrophy of either ventricle?  | YES / NO(If YES, please provide details in SECTION 7) |

|  |  |  |
| --- | --- | --- |
| **F.** | **Cardiomyopathy**  |  |
| (a) | Is there established cardiomyopathy? | YES / NO(If YES, please give details in SECTION 7) |
| (b) | Has there been a heart or heart/lung transplant?  | YES / NO(If YES, please give details in SECTION 7) |

|  |  |  |
| --- | --- | --- |
| **G.** | **Congenital Heart Disorders**  |  |
| (a) | Is there a congenital heart disorder? | YES / NO |
| If YES, is it CURRENTLY regarded as minor?  | YES / NO |
| (b) | Is the patient in the care of a specialist clinic?  | YES / NO(If YES, please give details in SECTION 7) |

### SECTION 7: FURTHER DETAILS

|  |
| --- |
| Please provide any other information as necessary (use additional sheets if required) |

**MEDICAL PRACTITONER’S DECLARATION**

**Name of doctor** *(please print)*

**Name and address of practice** *(official stamp is required)*

### Part A

I hereby certify that by completing Part B of this medical certificate, I have had regard of all the applicant’s medical records.

Signature……………………………………………………………………Date……………………………

### Part B

I hereby certify that (applicant name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(date of birth)\_\_\_\_\_\_\_\_\_\_ of (applicant’s address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

is fit to drive a Hackney Carriage/Private Hire Vehicle having regard to ALL the medical criteria for GROUP 2 ENTITLEMENT as detailed in the latest edition of the document ‘Medical Practitioners at a Glance Guide to the Current Medical Standards of Fitness to Drive’, issued by the Drivers Medical Group, DVLA, Swansea

Signature……………………………………………………………………Date……………………………

**Privacy Notice**

T*he Council will process your personal data in accordance with Data Protection Legislation. For more information and access to privacy notices outlining how the Council handles your personal data, please go to the Data Protection section of the Council's website* <http://www.torfaen.gov.uk>

**Hysbysiad Preifatrwydd**

*Bydd y Cyngor yn prosesu eich data personol yn unol â Deddfwriaeth Diogelu Data.  Am fwy o wybodaeth a mynediad at hysbysiadau preifatrwydd yn amlinellu sut mae’r Cyngor yn trin eich data personol, ewch i adran Diogelu Data gwefan y Cyngor* <http://www.torfaen.gov.uk>