MEDICAL REPORT
Associated with an application for a
Hackney Carriage or Private Hire Driver's Licence

SECTION 57(2) LOCAL GOVERNMENT (MISCELLANEOUS PROVISIONS) ACT 1976

For the Applicant:

This medical report is the method by which North Devon District Council is advised that the applicant is medically fit to drive hackney carriage/private hire vehicles.

Applicants must be examined and certified as being medically fit (to a Group 2 Standard) by their registered GP or another GP in the practice with which they are registered, who must have taken into account previous medical history.

PLEASE NOTE: If you are unable to obtain an appointment with your registered practice then the alternative is that you contact D4Drivers to arrange an appointment. D4Drivers hold regular clinics in Exeter and Taunton including on weekends, and they can be used as an alternative to your own GP. The medical fee is £55 including the eye test. To book an appointment with D4Drivers call 0300 3030 668 or go to their website https://d4drivers.uk/

- **YOU MUST obtain a summary of your medical history and current medication from your registered practice to take with you to the appointment.**

The Council may require a further examination or referral following this initial report.

You will be required to pay for your medical. The Council accepts no liability to pay for ANY costs associated with obtaining a medical report.

If this is your first application for a hackney carriage or private hire driver's licence, please note that further medical certificates will be required every five years. Drivers aged 65 and over must provide a medical certificate annually.

Vision Assessment

The Group 2 Medical includes a vision assessment. Some doctors will be able to assess both the vision and medical assessment sections of the report. If your doctor is unable to fully answer all the questions on the vision assessment you must also gain a report from an optician or optometrist.

If you do not wear glasses to meet the eyesight standard or if you have a minus (-) eyesight prescription, your doctor may be able to fill in the whole report.

It is suggested that before arranging an appointment that you check that your doctor is able to measure the visual acuity to the 6/7.5 line of a Snellen chart and can confirm the strength of your glasses (dioptres) from your prescription. If you wear glasses (not contact lenses) to meet the eyesight standard required for driving, you must take a copy of your current prescription clearly showing your dioptre measurements with you to the assessment.

For the Applicant's Doctor:

This medical report and any supplementary information is for the confidential use of the Council.

North Devon District Council has adopted the Group 2 Medical Standards for Fitness to Drive Hackney Carriage and Private Hire Vehicles in accordance with the Driver and Vehicle Licensing Agency (DVLA) and Department for Transport Best Practice Guidance.

The Appendix D criteria for insulin treated diabetes is adopted in relation to hackney carriage and private hire drivers.

Group 2 Medical reports are only accepted from the applicant's own doctor, another doctor in the same practice, or an alternative doctor approved by the Council, taking into account an applicant's medical records.

In completing this certificate, GPs are asked to have regard to the document "Assessing Fitness to Drive" (current edition) published by the Department for Transport and available at

https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals

Vision Assessment

Only complete the vision assessment question if you are able to do so fully and accurately.

In order to undertake the vision assessment you must be able to confirm the strength of glasses (dioptres) from a prescription.

You must be able to measure the applicant's visual acuity to at least 6/7.5 (decimal 0.8) of a Snellen chart.

We have advised the applicant that if they wear glasses to meet the required eyesight standard for driving they must bring their current prescription to the assessment.

If you are unable to undertake the vision assessment you must advise the applicant of this and the need for them to arrange to gain a DVLA D4 Vision Assessment form to attach to this certificate from their optician or optometrist.

Where applicants are required to go to an optician or optometrist, there is still a need for the applicant's doctor to undertake the final sign off of the medical certificate and indicate whether based on the information the driver concerned is fit or unfit to drive a hackney carriage/private hire vehicle.

MEDICAL EXAMINATION REPORT

VISION ASSESSMENT

To be filled in by a doctor or optician/optometrist.

You MUST read the guidance notes on page 2 before completing this report.

Applicant's full name	
Applicant's date of birth	

	VISION ASSESSMENT	YES	NO
1	Please confirm the scale you are using to express the driver's visual acuities. Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐		
2	a. Please provide uncorrected visual acuities for each eye. RIGHT: LEFT:		
	b. Are corrective lenses worn for driving? **If NO go to question 3.** If **YES**, please provide the visual acuities using the correction worn for driving. RIGHT: LEFT:	☐	☐
	c. What kind of corrective lenses are worn to meet this standard? glasses ☐ contact lenses ☐ both together ☐		
	d. If glasses (not contact lenses) 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.	☐	☐
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 details and dates in Q7	☐	☐
4	Is there diplopia? (a) If **YES**, is it controlled? If **YES**, please give details and dates in Q7	☐ ☐	☐ ☐
5	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 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? If **YES**, please give details and dates in Q7 below.	☐	☐
7	Details/additional information for previous questions.		

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 or GMC number	
Doctor/optometrist/optician's stamp	

MEDICAL EXAMINATION REPORT

MEDICAL ASSESSMENT

To be filled in by a doctor that has access to the applicant's medical records and history.

Applicant's full name	
Applicant's date of birth	

Please tick the appropriate box(es)

	SECTION 1: NEUROLOGICAL DISORDERS	**YES**	**NO**
	Is there a history of, or evidence of any neurological disorder? **If NO, go to Section 2, Diabetes mellitus** If **YES**, please answer **all** the questions below, give details in Section 10.	☐	☐
1	Has the applicant had any form of seizure?	☐	☐
	a. Has the applicant had more than one attack?	☐	☐
	b. Please give the date of first and last attack First attack: …….. Last attack: ……..…..		
	c. Is the applicant currently on any anti-epileptic medication? If **YES**, please fill in current medication in Section 8	☐	☐
	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 10	☐	☐
	f. Has the applicant had an EEG? If **YES** to any of the above, please supply reports if available.	☐	☐
2	Has the applicant had an episode(s) of non-epileptic attack disorder?	☐	☐
	If YES, please give date of most recent episode. ……..		
	If YES, have any of these episodes occurred or are they likely to occur whilst driving	☐	☐
3	Stroke or TIA? If '**YES'**, please give date ……..……..……..	☐	☐
	Has there been **FULL** recovery?	☐	☐
	Has a carotid ultrasound been undertaken? If **YES**, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
	Is there a history of multiple strokes/TIAs?	☐	☐
4	Sudden and disabling, dizziness/vertigo within the last year with a liability to recur?	☐	☐
5	Subarachnoid haemorrhage?	☐	☐
6	Serious traumatic brain injury within the past 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?	☐	☐

SECTION 2: DIABETES MELLITUS		**YES**	**NO**
	Does the applicant have diabetes mellitus? **If NO, go to Section 3, Cardiac** 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 10	☐	☐
	(c) Other injectable treatments?	☐	☐
	(d) A Sulphonyl urea or a Glinide?	☐	☐
	(e) Oral hypoglycaemic agents and diet?	☐	☐
	If **YES** to any of (a)-(e), please fill in current medication in Section 8		
	(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 dates and details in Section 10	☐	☐
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 10		
6	Has there been laser treatment or intra-vitreal treatment for retinopathy? If **YES**, please give date(s) of treatment	☐	☐

SECTION 3: CARDIAC		**YES**	**NO**
A. CORONARY ARTERY DISEASE			
Is there a history of, or evidence of, coronary artery disease? **If NO, go to Section 3B Cardiac Arrhythmia** If **YES**, please answer **all** questions below and give details in Section 10.		☐	☐
1	Has the applicant suffered from angina? If **YES,** please give date of the last known attack ……..	☐	☐
2	Acute coronary syndrome including myocardial infarction? If **YES**, please give date. ……	☐	☐
3	Coronary Angioplasty (PCI)?	☐	☐

	If **YES** please give date of most recent intervention? ……		
4	Coronary artery bypass graft surgery? 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?	☐	☐

B. CARDIAC ARRHYTHMIA		**YES**	**NO**
Is there a history of, or evidence of, cardiac arrhythmia? **If NO, go to Section 3c, peripheral arterial disease** If **YES**, please answer **all** questions below and give details in Section 10.		☐	☐
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?	☐	☐
2	Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐
3	Has an ICD or biventricular pacemaker (CRT-D type) been implanted?	☐	☐
4	Has a pacemaker or biventricular pacemaker (CRT-P type) been implanted?	☐	☐
	If **YES**: (a) Please give date of implantation		
	(b) Is the applicant free of 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		**YES**	**NO**
Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm / dissection? **If NO, go to Section 3d, Valvular/congenital heart disease** If **YES**, please answer **all** questions below and give details in Section 10.		☐	☐
1	Peripheral arterial disease (excluding Buerger's disease)	☐	☐
2	Does the applicant have claudication?	☐	☐
	If **YES**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited? Please give details		
3	Aortic aneurysm If **YES:** (a) Site of Aneurysm: Thoracic ☐ Abdominal ☐	☐	☐
	(b) Has it been successfully repaired?	☐	☐
	(c) Please provide latest transverse aortic diameter measurement and date obtained ……cm date:……		
4	Dissection of the aorta repaired successfully? If **YES**, please provide copies of all reports to include those dealing with any surgical treatment.	☐	☐
5	Is there a history of Marfan's disease? If **YES**, please provide details in section 10.	☐	☐

D. VALVULAR / CONGENITAL HEART DISEASE		**YES**	**NO**
Is there a history of, or evidence of, valvular/congenital heart disease? **If NO, go to Section 3e, Cardiac other** If **YES**, please answer **all** questions below and give details in Section 10.		☐	☐
1	Is there a history of congenital heart disease?	☐	☐

2	Is there a history of heart valve disease?	☐	☐
3	Is there a history of aortic stenosis? If **YES**, please provide relevant reports	☐	☐
4	Is there any history of embolism? (not pulmonary embolism)	☐	☐
5	Does the applicant currently have significant symptoms?	☐	☐
6	Has there been any progression since the last licence application? (if relevant)	☐	☐

E. CARDIAC OTHER		**YES**	**NO**
Is there a history of, or evidence of heart failure? **If NO, go to Section 3f, Cardiac Channelopathies** If **YES**, please answer **all** questions and provide details in Section 10.		☐	☐
1	Please provide the NYHA class, if known. ……		
2	Established cardiomyopathy?	☐	☐
3	Has a left ventricular assist device (LVAD) been implanted?	☐	☐
4	A heart or heart/lung transplant?	☐	☐
5	Untreated atrial myxoma?	☐	☐

F. CARDIAC CHANNELOPATHIES		**YES**	**NO**
Is there a history of, or evidence of either of the following conditions? **If NO, go to Section 3g, Blood pressure**		☐	☐
1	Brugada syndrome?	☐	☐
2	Long QT syndrome? If **YES**, to either, please give details in Section 10.	☐	☐

G. BLOOD PRESSURE		**YES**	**NO**
If resting blood pressure is 180mm/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? If **YES**, please provide three previous readings with dates if available 1. …… Date …… 2. …… Date …… 3. …… Date ……	☐	☐
3	Is there a history of malignant hypertension? If **YES**, please provide details in Section 10 (including date of diagnosis and any treatment etc.)	☐	☐

H. CARDIAC INVESTIGATIONS		**YES**	**NO**
Have any cardiac investigations been undertaken or planned? **If NO, go to Section 4, Psychiatric illness** If **YES**, please answer questions 1-7		☐	☐
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 comment at Section 10	☐	☐

2	Has an exercise ECG been undertaken or planned? If **YES**, please give date …….. and give details in Section 10	☐	☐
3	Has an echocardiogram been undertaken or planned?	☐	☐
	(a) If **YES**, please give date …….. and give details in Section 10	☐	☐
	(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?	☐	☐
4	Has a coronary angiogram been taken or planned? If **YES**, please give date …….. and give details in Section 10	☐	☐
5	Has a 24 hour ECG tape been undertaken or planned? If **YES**, please give date …….. and give details in Section 10	☐	☐
6	Has a myocardial perfusion scan or stress echo study been undertaken or planned? If **YES**, please give date …….. and give details in Section 10	☐	☐
7	Date last seen by a consultant specialist for any cardiac condition declared ……		

SECTION 4: PSYCHIATRIC ILLNESS		**YES**	**NO**
Is there a history of, 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		☐	☐
1	Significant psychiatric disorder within the past 6 months? If YES please confirm condition: ……	☐	☐
2	Psychosis or hypomania/mania, within the past 12 months, including psychotic depression?	☐	☐
3	Dementia or cognitive impairment?	☐	☐

SECTION 5: SUBSTANCE MISUSE		**YES**	**NO**
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		☐	☐
1	Is there a history of alcohol dependence in past 6 years?	☐	☐
	If YES (a) is it controlled	☐	☐
	(b) Has the applicant undergone an alcohol detoxification programme?	☐	☐
	(c) has the applicant undertaken an opiate treatment programme? If YES, date started: ……	☐	☐
2	Persistent alcohol misuse in the past 3 years?	☐	☐
	(a) Is it controlled?	☐	☐
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 ……		

SECTION 6: SLEEP DISORDERS		**YES**	**NO**
All questions must be answered. If **YES** to any, give full details in Section 10			
1	Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? **If NO, go to Section 7, Other medical conditions** 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 an AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. Please give details in Section 10			
	(b) Please answer questions (i) – (vi) for **all** sleep conditions			
	(i)	Date of diagnosis ……..		
	(ii)	Is it controlled successfully?	☐	☐
	(iii)	If **YES**, please state treatment		
	(iv)	Is applicant compliant with treatment?	☐	☐
	(v)	Please state period of control ……. years …….. months		
	(vi)	Date of last review ……..		
2	Is there a history or evidence of narcolepsy?		☐	☐

SECTION 7: OTHER MEDICAL CONDITIONS		**YES**	**NO**
1	Is there currently any functional impairment which is likely to affect control of the vehicle?	☐	☐
2	Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	☐	☐
3	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	☐	☐
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?	☐	☐
5	Does the applicant have a history of liver disease of any origin? If **YES**, please give details in Section 10	☐	☐
6	Is there a history of renal failure? If **YES**, please give details in Section 10	☐	☐
7	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
8	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 10	☐	☐
9	Does the applicant have any other medical condition that could affect safe driving? If **YES**, please give details in Section 10	☐	☐

SECTION 8: MEDICATION

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

Medication	**Dosage**	**Reason for taking**

SECTION 9: CONSULTANTS' DETAILS

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

Consultant in	
Reason for attendance	
Name	
Address	
Date of last appointment	

Consultant in	
Reason for attendance	
Name	
Address	
Date of last appointment	

SECTION 10: FURTHER DETAILS

Please provide any further details from other sections. Please continue on separate sheet if required.

SECTION 11: EXAMINING DOCTOR'S SIGNATURE AND STAMP

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 don't 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.

I have examined the applicant named below and having seen and paid full regard to his/her medical history and the criteria for a Group 2 vocational driver's licence as set out in the latest edition of the DVLA publication 'for Medical Practitioners – at a Glance Guide for Current Medical Standards of Fitness to Drive'.

I certify that the applicant is (√ as appropriate):

FIT ☐

UNFIT ☐

to act as the driver of a Hackney Carriage or Private Hire Vehicle.

Name of Doctor:
Address:
Telephone:
Email address:
Surgery Stamp:
Signature of Medical Practitioner
Date of signature
Have you reviewed the applicant's medical records? **YES** ☐ **NO** ☐ If reviewing a print out of the medical records, please give the date of the printout:

If you have filled in both, the vision and medical assessments, both Sections must be signed and dated.

SECTION 12: APPLICANTS DETAILS AND DECLARATION

You **must** fill in this Section and **must not** alter it in any way.
Please read the following important information carefully then sign to confirm the statements below.

Important information about fitness to drive
As part of the investigation into your fitness to drive, we North Devon District Council may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness to drive.

Declaration
I authorise my doctor and specialist to release reports and information about my condition which is relevant to my fitness to drive, to North Devon District Council.

I understand that North Devon District Council may disclose relevant medical information that is necessary to investigate my fitness to drive, to doctors and paramedical staff.

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.

Name:	
Address:	
Telephone:	Home …… Work/Daytime ……..
Mobile:	
Email:	
Signature	
Date of signature	

If this medical report has been completed by a doctor who is NOT your registered GP please provide the following information:

Registered GP's name	
Registered GP's practice name and address	

Please ensure all pages of this report have been completed.

This report is valid for 4 months from the date the doctor, optician or optometrist signs it.

Privacy Notice – privacy & data protection

North Devon Council, the Data Controller, collects personal information when you contact us for the licensing services we provide. We will use this information to provide these services, such as the granting of a licence, permit, registration or receipt of a notice.

We may need to share your information with other departments in North Devon Council or external/ third parties, where this is necessary to perform our public functions & services as provided by law.

For more information as a Data Subject regarding privacy & data protection, including how we manage your personal information, data retention and your rights, please see our Privacy Notice on the website: www.northdevon.gov.uk/privacy