

Licensing Section Processing Team, Stakeford Depot. East View, Stakeford, NE62 5TR

**MEDICAL CERTIFICATE ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A
HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE**

Applicant's details: (please complete)

Full name: **Date of birth:**

Current address:

Applicant's consent and declaration: (Please read the following carefully before signing and dating the declaration).

I authorise my General Practitioner(s) and Specialist(s) to release medical information about my condition, together with any relevant information relevant to fitness to drive, to the Licensing Section, Northumberland County Council for the purpose of the Council (by its Officers and/or Members) of assessing my fitness to drive a hackney carriage or private hire vehicle licensed by that Council.

I declare that to the best of my knowledge and belief all information given by me to my doctors in connection with the examination or the completion of the DVLA Group 2 medical examination report are true. In the event that the Council is not satisfied of my fitness to drive a hackney carriage or private hire vehicle, I confirm that I may, at my own cost, submit such further medical evidence to the Council as I consider appropriate.

Signed: **Date:**

TO THE G.P. This form must be completed in full by the applicant's own G.P. or a medical practitioner who has reviewed the applicant's medical records. Please answer all questions and once completed sign the declaration at the end.

The Councils' policy on medical fitness requires that taxi drivers meet Group 2 Entitlement, as set out in the DVLA publication 'A Guide to the current Medical Standards of Fitness to Drive'. This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to taxi drivers.

(a)	Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?	YES	NO
(b)	Have you reviewed the above applicant's medical records?	YES	NO

1.	VISION:
-----------	----------------

i	Please confirm (✓) the scale you are using to express the driver's visual acuities.	Yes	No
	<div style="display: flex; justify-content: space-between;"> Snellen <input type="checkbox"/> Snellen expressed as a decimal <input type="checkbox"/> LogMAR <input type="checkbox"/> </div>		
ii	Please state the visual acuity of each eye. Snellen readings with a plus (=) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician. <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Uncorrected Right <input style="width: 60px; height: 30px;" type="text"/> Left <input style="width: 60px; height: 30px;" type="text"/> </div> <div style="text-align: center;"> Corrected (if applicable) Right <input style="width: 60px; height: 30px;" type="text"/> Left <input style="width: 60px; height: 30px;" type="text"/> </div> </div>		
iii	Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard)?	Yes	No
iv	Were corrective lenses worn to meet this standard?	Yes	No
	If Yes , glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> both together <input type="checkbox"/>		
v	If glasses (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptries in any meridian of either lens?	Yes	No
vi	If correction is worn for driving, is it well tolerated? If No , please give full details in Section 8 .		

vii	Is there a history of any medical condition that may affect the patients' binocular field of vision (central and/or peripheral)?						
viii	Is there diplopia					Yes	No
	(a) If Yes , is it controlled? Please provide details in Section 8					Yes	No
ix	Does the patient on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision?					Yes	No
x	Does the applicant have any other ophthalmic condition?					Yes	No
	If Yes , to any questions 7-10, please give full details in Section 8 .						
2.	NERVOUS SYSTEM						
i	Has the patient had any form of seizure? If YES please answer questions a – f below.					YES	NO
	(a) Has the patient had more than one attack?					Yes	No
	(b)	Please give date of first and last attack:	1 st attack	Last attack	
	(c) Is the patient currently on anti-epilepsy medication? If YES please give details of current medication:					Yes	No
	(d) If treated, please give date when treatment ended:						
	(e) Has the patient had a brain scan? If YES please state dates and supply reports if available.					Yes	No
	<div style="display: flex; justify-content: space-around;"> MRI CT </div>						
	(f) Has the patient had an EEG? If YES please provide date and supply reports if available:					Yes	No
ii	Is there a history of blackout or impaired consciousness within the last 5 years? If YES please give dates and details at Section 8 :					Yes	No
iii	Is there a history of, or evidence of, any of the conditions listed at a – h below? If NO go to Section 3 . If YES please answer the following questions, give dates and full details and supply any relevant reports.					Yes	No
	(a) Stroke / TIA (<i>please delete as appropriate</i>) If YES please give date:					Yes	No
	Has there been a full recovery?					Yes	No
	Has a carotid ultra sound been undertaken?					Yes	No
	If YES , was the carotid artery stenosis >50% in either carotid artery?					Yes	No
	Has there been a carotid endarterectomy?					Yes	No
	(b) Sudden and disabling dizziness/vertigo within the last one year with a liability to recur					Yes	No
	(c) Subarachnoid haemorrhage					Yes	No
	(d) Serious traumatic brain injury within the last 10 years					Yes	No
	(e) Any form of brain tumour?					Yes	No
	(f) Other brain surgery/abnormality					Yes	No
	(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis					Yes	No
	(h) Does the patient suffer from narcolepsy?					Yes	No

3.	DIABETES MELLITUS		
i	Does the patient have diabetes mellitus? If NO please go to Section 4 . If YES please answer the following questions.	YES	NO
ii	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 8 (c) Other injectable treatments? (d) A Sulphonylurea or a Glinide? (e) Oral hypoglycaemic agents and diet? If YES to any of (a)-(e) please provide details of medication in section8 : (f) Diet only?	Yes	No
iii	Does the patient test blood glucose at least twice every day?	Yes	No
iv	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)?	Yes	No
v	Does the applicant keep fast acting carbohydrate within easy reach when driving?	Yes	No
vi	Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	Yes	No
v	Is there evidence of:- (a) Loss of visual field? (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? (c) Impaired awareness of hypoglycaemia?	Yes	No
vii	Has there been any laser treatment or intra-vitreous for retinopathy? If YES please give date(s) of treatment	Yes	No
viii	Is there a history of hypoglycaemia in the last 12 months requiring assistance? If YES to any of 6 – 8 above please give details in Section 8 .	Yes	No
4	PSYCHIATRIC ILLNESS		
	Is there a history of, or evidence of any of the conditions listed at 1 – 7 below? If NO please go to Section 5 . If YES please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in Section 8 . (Please enclose relevant notes). (If patient remains under specialist clinic(s) please give details in Section 8).	YES	NO
i	Significant psychiatric disorder within the past 6 months?	Yes	No
ii	A psychotic illness or hypomania/mania within the past 12 months, including psychotic depression?	Yes	No
iii	Dementia or cognitive impairment?	Yes	No
iv	Persistent alcohol misuse in the past 12 months?	Yes	No
v	Alcohol dependency in the past 3 years?	Yes	No
vi	Persistent drug misuse in the past 12 months?	Yes	No
vii	Drug dependency in the past 3 years	Yes	No

5	CARDIAC	
	<p>Is there a history of, or evidence of, Coronary Artery Disease? If NO please go to Section 5B If YES please answer all questions below and give details at Section 8 of the form and enclose relevant hospital notes.</p>	YES NO
5A	CORONARY ARTERY DISEASE	
i	<p>Acute Coronary Syndromes including Myocardial Infarction? If YES please give date(s):</p>	Yes No
ii	<p>Coronary artery by-pass graft surgery? If YES please give date(s):</p>	Yes No
iii	<p>Coronary Angioplasty (P.C.I.)? If YES please give date of most recent intervention:</p>	Yes No
iv	<p>Has the patient suffered from Angina? If YES please give the date of the last attack:</p>	Yes No
v	<p>If Yes to any of the above, are there any physical health problems (eg mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?</p>	Yes No
	Please go to next Section 5B	
5B	CARDIA ARRHYTHMIA	
	<p>Is there a history of, or evidence of, cardiac arrhythmia? If NO, go to Section 5C If YES please answer all questions below and give details in Section 8 of the form</p>	YES NO
i	<p>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 last 5 years?</p>	Yes No
ii	<p>Has the arrhythmia been controlled satisfactorily for at least 3 months?</p>	Yes No
iii	<p>Has an ICD or biventricular pacemaker (CRST-D type) been implanted?</p>	Yes No
iv	<p>Has a pacemaker been implanted? If YES:</p> <p>(a) Please supply date:</p> <p>(b) Is the patient free of symptoms that caused the device to be fitted?</p> <p>(c) Does the patient attend a pacemaker clinic regularly?</p>	<p>Yes No</p> <p>Yes No</p> <p>Yes No</p>
	Please go to next Section 5C	
5C	PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION	
	<p>Is there a history or evidence of ANY of the following: If NO go to Section 5D. If YES please answer the questions below and give details in Section 8 of the form.</p>	YES NO
i	Peripheral Arterial Disease (excluding Buerger's Disease)	Yes No
ii	<p>Does the patient have claudication? If YES please give details as to how long in minutes the patient can walk at a brisk pace before being symptom limited</p>	Yes No
iii	<p>Aortic Aneurysm If YES:</p> <p>(a) Site of Aneurysm (please tick): Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/></p> <p>(b) Has it been repaired successfully?</p> <p>(c) Is the transverse diameter currently >5.5 cms?</p> <p>If NO please provide latest measurement: Date obtained:</p>	<p>Yes No</p> <p>Yes No</p>

iv	Dissection of the Aorta repaired successfully If YES please provide copies of all reports to include those dealing with any surgical treatment.	Yes	No
v	Is there a history of Marfan's disease? If Yes , please provide relevant hospital notes.	Yes	No
Please go to next Section 5D			
5D	VALVULAR/CONGENITAL HEART DISEASE		
	Is there a history of, or evidence of, valvular/congenital heart disease? If NO go to Section 5E If YES please answer all questions below and give details in Section 8 of the form	YES	NO
i	Is there a history of congenital heart disorder?	Yes	No
ii	Is there a history of heart valve disease?	Yes	No
lii	Is there a history of aortic stenosis? If Yes , please provide relevant reports	Yes	No
iv	Is there any history of embolism? (not pulmonary embolism)	Yes	No
v	Does the patient currently have significant symptoms?	Yes	No
vi	Has there been any progression since the last licence application? (if relevant)	Yes	No
5E	CARDIAC OTHER		
	Does the patient have a history of ANY of the following conditions: If NO go to Section 5F If YES please answer all questions below and give details in Section 8 of the form	YES	NO
	(a) A history of, or evidence of, heart failure?	Yes	No
	(b) Established cardiomyopathy?	Yes	No
	(c) Has a left ventricular assist device (LVAD) been implanted?	Yes	No
	(d) A heart or heart/lung transplant?	Yes	No
	(e) Untreated atrial myxoma?	Yes	No
5F	CARDIAC INVESTIGATIONS (This section must be filled in for all patients) (Please provide relevant reports)		
	Have any cardiac investigations been undertaken or planned?	YES	NO
i	Has a resting ECG been undertaken? If YES does it show:	Yes	No
	(a) Pathological Q waves?	Yes	No
	(b) Left bundle branch block?	Yes	No
	(c) Right bundle branch block?	Yes	No
	If Yes , to a, b or c please give details in Section 8 .		
ii	Has the exercise ECG been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
iii	Has an echocardiogram been undertaken (or planned)? (a) If YES please give date and give details in Section 8 : (b) If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?	Yes	No
iv	Has a coronary angiogram been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
v	Has a 24 hour ECG tape been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No

vi	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)? If YES please provide date and give details in Section 8 :	Yes	No
Please go to next Section 5G			
5G	BLOOD PRESSURE (This section must be filled in for all patients)		
i	Is today's best systolic pressure reading 180mm Hg or more? (Please give reading) (BP reading:)	Yes	No
ii	Is today's best diastolic pressure reading 100mm Hg or more? (Please give reading) (BP reading:)	Yes	No
iii	Is the patient on anti-hypertensive treatment? If YES to any of the above please provide three previous readings with dates if available: 1. B.P reading: Date: 2. B.P reading: Date: 3. B.P reading: Date:	Yes	No
6.	GENERAL (Please answer all questions in this section. If your answer is YES to any question please give full details in Section 8 .)		
i	Is there currently any functional impairment that is likely to affect control of the vehicle?	Yes	No
ii	Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? If YES please give dates and diagnosis and state whether there is current evidence of dissemination?	Yes	No
iii	Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	Yes	No
iv	Is the patient profoundly deaf? If YES is the patient able to communicate in the event of an emergency by speech or by using a device e.g. a textphone?	Yes	No
v	Is there a history of liver disease of any origin? If Yes , please give details in Section 8	Yes	No
vi	Is there a history of either renal failure? If Yes , please give details in Section 8	Yes	No
vii	Is there a history of, or evidence of, obstructive sleep apnoea syndrome? If YES please provide details If Obstructive Sleep Apnoea Syndrome, please indicate the severity: Mild (AHI <15) <input type="checkbox"/> Moderate (AHI 15 -29) <input type="checkbox"/> Severe (AHI > 29) <input type="checkbox"/> If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. Please give details in Section 8 (a) Date of diagnosis:	Yes	No

[illegible]

GP'S DECLARATION: Please read the following carefully before completing, signing and dating the declaration.

If the applicant/patient is not a registered patient with your practice or you have not reviewed his/her medical records then do not complete the declaration.

I certify that I am familiar with the current requirements of **Group 2 medical standards** applied by the DVLA in the current version of "Medical Standards of Fitness to Drive".

I certify that I have reviewed the applicant's medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.

I certify that I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a Hackney Carriage or Private Hire driver under the DVLA Group 2 medical standards

I certify that having regard to the foregoing, the applicant * MEETS / DOES NOT MEET (*delete as appropriate) the minimum standards required for the DVLA Group 2 medical standards.

Doctor's name:		Surgery Stamp:
Surgery name:		
Surgery address:		
Signed:		Date: