



Medical Certificate

(2023)

To certify that an applicant for a Hackney Carriage or Private Hire Driver's licence is fit to drive the public.

Note to Applicant

This medical may only be completed by your own GP with whom you are register, OR any other GP within the same practice, who has full access to your medical records.

A minority of GP surgeries do not provide these types of medicals. It is only in these circumstances that this form can be completed by an alternative GP / Medical Practitioner who has **full access** to your summary of medical records.

Assessments must not be completed more than one calendar month before a licence is applied for or renewed.

You are responsible for any fees charged by your GP / Medical Practitioner.

Note to Doctor

You should be aware that "Medical Aspects of Fitness to Drive" published by the medical Commission, on Accident Prevention in 1995, recommended that the **Group 2** Medical Standards applied by the DVLA to bus and lorry drivers should also the applied by Local Authorities, to taxi Drivers. The DVLA leaflet INF4D may be used as a reference document and can be viewed on line [Medical examination report for a lorry or bus driving licence \(D4\) - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

Applicant Details (please print in capitals)

Full Name:	
Date of Birth:	
Address including postcode:	
Telephone number:	
Email address:	

I authorise my General Practitioner(s) to provide information requested on this form relevant to my fitness to drive a licenced hackney carriage or private hire vehicle to Burnley Borough Council in order to assess my fitness to hold a hackney carriage or private hire driver's licence.

I declare that to the best of my knowledge and belief all information given by me to my GP or Doctor in connection with this examination is true.

Signed:

Date:

Please provide details of the Surgery you are registered with:

Name of your Doctor:

Name of Surgery:

Address including postcode:

Telephone number:

Email Address:

Details of the Examining Doctor (to be completed by the doctor carrying out the examination)

First Name:

Surname:

Address including postcode:

Phone Number:

Email Address:

GMC Registration Number:

GP (Doctor) Signature:

Driver Identification (to be completed by the doctor carrying out the examination)

Documents seen:

Passport:

Yes / No

DVLA driver photo card:

Yes / No

Verified against patient records:

Yes / No

Applicants Date of Birth:

Medical Examination Report

The Patient

1	Weight (kg / st)		
2	Height (cms / ft)		
3	Please give details of smoking habits, if any:		
4	Please give number of alcohol units taken each week:		
5	Has the urine sample been taken, positive for Glucose?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6	Is the applicant currently seeing a specialist or consultant?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7	Current medication including exact dosage and reason for each treatment:	Continue on Page 7 if necessary	

VISION

1	Please confirm (✓) the scale you are using to express the driver's visual acuities.	Snellen <input type="checkbox"/> Snellen expressed as a decimal <input type="checkbox"/> LogMAR <input type="checkbox"/>	
2	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.	Uncorrected R = L =	Corrected R = L =
3	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 <input type="checkbox"/>	NO <input type="checkbox"/>
4	Were corrective lenses worn to meet this standard? If YES, glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> both together <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5	If glasses (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6	If correction is worn for driving, is it well tolerated? If NO, please give full details in the box provided. If you answer yes to any of the following give details in the box provided.	YES <input type="checkbox"/> (Please provide details)	NO <input type="checkbox"/> (Please provide details)
7	Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If formal visual field testing is considered necessary, DVLA will commission this at a later date.	YES <input type="checkbox"/>	NO <input type="checkbox"/>

8	Is there diplopia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	If YES, is it controlled? If YES, please give full details in the box provided.	YES <input type="checkbox"/> (Please provide details)	
9	Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
10	Does the applicant have any other ophthalmic condition? If YES, please give full details in the box provided	YES <input type="checkbox"/> (Please provide details)	NO <input type="checkbox"/>

NERVOUS SYSTEM

1	Has the applicant had any form of epileptic attack?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	(a) If Yes, please give date of last attack:	<input type="text"/>	<input type="text"/>
	(b) If treated, please give date when treatment ceased	<input type="text"/>	<input type="text"/>
2	Is there a history of blackout or impaired consciousness within the last 5 years?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3	Does the applicant suffer from narcolepsy / cataplexy?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4	Is there a history of, or evidence of any of the conditions below? <ul style="list-style-type: none"> • Stroke/ TIA (please delete as appropriate) • Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur • Subarachnoid haemorrhage • Serious head injury within the last 10 years • Brain tumour, either benign or malignant, primary or secondary • Other brain surgery • Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis • Dementia or cognitive impairment 	YES <input type="checkbox"/> If yes, please give details at the end of this report	NO <input type="checkbox"/>

DIABETES MELLITUS

1	Does the applicant have diabetes mellitus?	YES <input type="checkbox"/> If yes, continue below	NO <input type="checkbox"/> If no, move to Psychiatric Illness
2	Is the diabetes managed by: - (a) Insulin? If YES, please give date started on insulin: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (b) Oral hypoglycaemic agents and diet? (c) Diet only?	YES <input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/>	NO <input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/>
3	Does the patient test blood glucose at least twice every day?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4	Is there evidence of loss of visual field?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

5	Is there evidence of severe peripheral neuropathy, sufficient to impair limb function for safe driving?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6	Is there evidence of diminished/absent awareness of hypoglycaemia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7	Has there been laser treatment for retinopathy?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
8	Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

PSYCHIATRIC ILLNESS

1	<p>Is there a history of, or evidence of any of the conditions listed below?</p> <ul style="list-style-type: none"> • Significant psychiatric disorder within the past 6 months? • A psychotic illness within the past 3 years including psychotic depression? • Persistent alcohol misuse in the past 12 months? • Alcohol dependency in the past 3 years? • Persistent drug misuse in the past 12 months? • Drug dependency in the past 3 years? 	<p>YES <input type="checkbox"/></p> <p><i>If yes, please give details at the end of this report</i></p>	<p>NO <input type="checkbox"/></p> <p><i>If no, move to the Cardiac section</i></p>
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CARDIAC

1	Is there a history of, or evidence of, coronary artery disease?	<p>YES <input type="checkbox"/></p> <p><i>If yes, please give details below and at the end of this report</i></p>	<p>NO <input type="checkbox"/></p> <p><i>If no, move to Cardiac Investigations</i></p>
2	Myocardial Infarction?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3	Coronary artery by-pass graft?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4	Coronary Angioplasty (with or without stent)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5	Has the applicant suffered from Angina?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6	Is there a history of, or evidence of, cardiac arrhythmia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7	Is there any history or evidence of PRIPHERAL ARTERIAL DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
8	Is there any history or evidence of AORTIC ANEURYSM	YES <input type="checkbox"/>	NO <input type="checkbox"/>
9	Is there any history or evidence of DISSECTION OF THE AORTA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
10	Is there any history or evidence of Valvular or congenital heart disease?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
11	<p>Does the applicant have a history of ANY of the following conditions:</p> <ul style="list-style-type: none"> • a history of, or evidence of heart failure? • established cardiomyopathy? • a heart or heart/lung transplant? 	<p>YES <input type="checkbox"/></p> <p><i>If yes, please give details below and at the end of this report</i></p>	<p>NO <input type="checkbox"/></p>

CARDIAC INVESTIGATIONS

1	Has a resting ECG been undertaken?	YES <input type="checkbox"/> If yes, continue below	NO <input type="checkbox"/> If no, move to Blood Pressure
2	If YES, does it show pathological Q waves?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3	If YES, does it show left bundle branch block?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4	Has an exercise ECG been undertaken (or planned)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5	Has an echocardiogram been undertaken (or planned)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6	Has a coronary angiogram been undertaken (or planned)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7	Has a 24-hour ECG tape been undertaken (or planned)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
8	Has a myocardial perfusion imaging scan been undertaken (or planned)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

BLOOD PRESSURE

1	Is today's resting systolic pressure 180mm Hg or greater?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2	Is today's resting diastolic pressure 100mm Hg or greater?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3	Is the applicant on anti-hypertensive treatment?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4	Please give today's BP reading:		

GENERAL HEALTH

1	Is there currently a disability of the spine or limbs, likely to impair control of the vehicle?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2	Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3	Is the applicant profoundly deaf?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4	If YES, is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/ text phone?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5	Is there a history of either renal or hepatic failure?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6	Does the applicant have sleep apnoea syndrome	YES <input type="checkbox"/>	NO <input type="checkbox"/>
7	If YES, has it been controlled successfully?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
8	Is there any other Medical Condition, causing excessive daytime sleepiness?	YES <input type="checkbox"/> If YES, please give full details at the end of this report.	NO <input type="checkbox"/>
9	Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
10	Does any medication currently taken cause the applicant side effects which impair his/ her safe driving?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
11	Is the applicant sufficiently active for the performance of his/her duties?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

ADDITIONAL INFORMATION

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General Practitioner (Doctor) Declaration
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Name of Applicant:	
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I certify that I have this day examined the above-named person and have completed the above medical certificate.

I am the named applicants GP/ Medical Practitioner with full access to the applicants NHS records / summary of medical records at the time of the examination.

I have reviewed the applicant's medical history and having today examined the applicant I consider the applicant:

Has met

Has Not met

Group 2 Standards of medical fitness, as applied by the DVLA to the licensing of lorry & bus drivers which is required for licenced hackney carriage and private hire driver's.

I declare that the answers to all questions are true to the best of my knowledge and belief. I understand that it is an offence for the person completing this form to make a false statement or omit any relevant details

Full name of GP:	
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Signature:	
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Date:	
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THIS SECTION SHOULD ONLY TO BE COMPLETED IF THIS MEDICAL CERTIFICATE HAS BEEN COMPLETED BY YOUR OWN GENERAL PRACTITIONER WITH WHOM YOU ARE REGISTERED, OR ANY OTHER GP WITHIN THE SAME PRACTICE WHO HAS FULL ACCESS TO YOUR RECORDS.

I CONSIDER THE APPLICANT SHOULD BE SUBJECT TO A FURTHER MEDICAL EXAMINATION IN:
(Please tick)

3 years (Applicable only to applicants when the medical form has been completed by applicant's own General Practitioner with whom he/she is registered, or any other GP within the same practice)

1 year

Other (Not longer than 3 years) Please specify.....years

NOTE.

All drivers who attain 65 years of age are required to undergo an annual medical examination.

Signature of Qualified & Registered Medical		Surgery Stamp:
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Practitioner:		
GMC Registration Number:		
Date:		