

**REPORT OF MEDICAL EXAMINATION OF  
APPLICANT FOR HACKNEY CARRIAGE  
OR PRIVATE HIRE DRIVERS LICENCE**

Local Government (Miscellaneous Provisions) Act 1976  
Town Police Clauses Act 1847

**APPLICANT DETAILS (to be completed by applicant)**

<b>1</b>	Forename	
<b>2</b>	Surname	
<b>3</b>	Address	
<b>4</b>	Date of birth	

**DECLARATION AND SIGNATURE (to be completed by applicant)**

- I hereby declare that I give consent to the medical examination being carried out.
- I hereby declare that the information contained within the questionnaire is true to the best of my knowledge.
- I hereby authorise the doctor to release reports and information about my medical fitness to the council.

<b>5</b>	Applicant's signature	
<b>6</b>	Date of signature	

**DECLARATION AND SIGNATURE (to be completed by the doctor)**

- I hereby declare that I am a registered doctor with access to the applicant's medical records.
- I hereby declare that I have considered the applicant's medical history.
- I hereby declare that I have identified the applicant prior to carrying out the assessment.
- I understand that the applicant is to be assessed in accordance with the DVLA's Group 2 Medical Standards (applicable to drivers of lorries and buses).

I hereby declare that, in my opinion, the applicant:

Has satisfied  **OR** Has not satisfied

the criteria laid down in the DVLA's Group 2 Medical Standards.

<b>7</b>	Doctor's name	
<b>8</b>	Doctor's signature	
<b>9</b>	Date of signature	







### 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.
- Please provide the NYHA class,  if known.
  - Established cardiomyopathy? Yes No  
 If Yes, please give details in section 9, page 7.
  - Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No
  - A heart or heart/lung transplant? Yes No
  - 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**
- Brugada syndrome? Yes No
  - 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.
- Please record today's best resting blood pressure reading.  /
  - Is the applicant on anti-hypertensive treatment? Yes No  
 If Yes, please provide three previous readings with dates if available.  
 /       
 /       
 /
  - 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.
- 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.**

- Has an exercise ECG been undertaken (or planned)? Yes No
- Has an echocardiogram been undertaken (or planned)? Yes No  
         
 (a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?
- Has a coronary angiogram been undertaken (or planned)? Yes No
- Has a 24 hour ECG tape been undertaken (or planned)? Yes No
- Has a loop recorder been implanted (or planned)? Yes No
- Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Yes No

### 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.
- Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition. Yes No
  - Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No
  - (a) Dementia or cognitive impairment? Yes No  
   
 (b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?

### 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.
- 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:
  - Persistent alcohol misuse in the past 3 years? Yes No  
   
 (a) Is it controlled?
  - Use of illegal drugs or other substances, or misuse of prescription medication in the last 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

Applicant's full name

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## 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. Please give details in section 9.

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

(i) Date of diagnosis:       Yes  No

(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:

## 7 Other medical conditions

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

2. Is there currently any functional impairment that is likely to affect control of the vehicle? Yes  No

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? Yes  No

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? Yes  No

5. 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

6. 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.

7. Is there a history of renal failure? Yes  No

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

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

9. 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.

10. 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:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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Applicant's full name

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## Notes

- If the doctor is unable to fully and accurately complete the Vision assessment you must arrange for an optician or optometrist to complete the assessment. Send the completed report (Vision and Medical assessment), application form and your driving licence to North Yorkshire Council.
- The council will not be responsible for any fees you have paid to a doctor and/or optician or optometrist, even if your application is ultimately refused.
- You must take a form of photographic identity to the examination, for example your passport or driving licence.
- Both examinations must have taken place and have been signed and dated by the doctor and optometrist/optician no more than one month before the date of the application being submitted to the council.

## Information for the doctor

- Please only complete the vision assessment if you are able to fully and accurately complete ALL questions. If you are unable to do this you must tell the applicant that they will need to arrange to have this part of the assessment completed by an optician or optometrist.
- Please ensure that you confirm the applicant's identity before examination. They have been advised of the need to produce photographic identification.
- Please examine the applicant fully and complete all relevant sections of the medical assessment, including a surgery/practice stamp in section 11.
- You must have regard to any information contained within the applicant's medical history when you fill in the report. Details of any condition which has not been covered by the report should be given in section 9.
- The applicant will be liable for any costs incurred.
- You may find it helpful to read the DVLA's Guide for medical professionals here: <https://www.gov.uk/dvla/fitnesstodrive>

## Information for the optician/optometrist

- The vision assessment can be completed by a doctor, optician or optometrist. In some cases the doctor may not be able to fully complete the report and will have advised the applicant to arrange an appointment with an optician/optometrist.
- Please ensure that you confirm the applicant's identity before examination. They have been advised of the need to produce photographic identification.
- Please complete all relevant sections of the vision assessment.
- Please make sure you answer all questions and provide any additional information in the box provided for details. Please include any consultant or specialist details.
- The applicant will be liable for any costs incurred.
- You may find it helpful to read the DVLA's Guide for medical professionals here: <https://www.gov.uk/dvla/fitnesstodrive>