

MEDICAL EXAMINATION GUIDANCE for a hackney carriage/private hire drivers licence

When making an application for either a hackney carriage or private hire driver's licence, you must be able to demonstrate that you are medically fit to drive by having a medical check with a doctor.

Once you have obtained a licence, you will need to undergo further medical checks at the age of 45 then every 5 years until the age of 65. After 65 you will need to have a medical every year.

Additionally, you may be required to have a medical outside of these times if your medical fitness changes.

Requirements for medical examinations

1. You must arrange an appointment with a GP to have your medical carried out.
2. You must complete the HC/PH Driver Medical Fitness Declaration found overleaf prior to attending your medical and then sign applicant consent and declaration at back of form.
3. Your medical examination must adhere to the DVLA's Group 2 Entitlement. Please refer to DVLA's "At a Glance Guide to the current Medical Standards of Fitness to Drive" for further information. –This can be found at: www.dft.gov.uk/dvla/medical/ataglance
4. You must declare any medication that you have been prescribed.
5. The GP must complete the declaration form at the end of the medical form to confirm whether you are fit to drive a licensed hackney carriage and/or a private hire vehicle.

All fees associated with the medical examination are payable direct by you. The Council is not responsible for fees and charges levied by your doctor.

What you have to do

Medical standards for professional drivers are stricter than for ordinary car drivers. If you have any concerns about your ability to meet the medical or eyesight standards, please speak to your doctor/optician **before** you make arrangements for a medical check with a doctor.

Please return this form to:

(If sending form via post we recommend that you either keep a copy of the completed form or send via recorded delivery to ensure receipt)

Fleet Compliance Team
Environmental Services
Wiltshire Council
County Hall
Bythesea Road
Trowbridge
Wiltshire
BA14 8JN
Tel: 01225 770271 Email: fleet.licensing@wiltshire.gov.uk

Hackney Carriage/Private Hire Driver Medical Fitness Declaration

Please advise if you have any of the following health issues:	Yes	No
Epilepsy, Fits or blackouts		
Repeated attacks of sudden disabling giddiness (dizziness that prevents you from functioning normally)		
Diabetes controlled by insulin		
Diabetes controlled by tablets		
An implanted cardiac pacemaker and / or An implanted cardiac defibrillator (ICD)		
Persistent alcohol and / or drug abuse or dependency		
Parkinson's disease		
Narcolepsy or sleep apnoea syndrome		
Stroke, with any symptoms lasting longer than one month, including recurrent 'mini strokes' or TIAs (Transient Ischaemic Attacks)		
Any type of brain surgery, severe head injury involving inpatient treatment, or brain tumour		
Any other chronic (long term) neurological condition		
A serious problem with memory or episodes of confusion		
Severe learning disability		
Serious psychiatric illness or mental ill-health		
Total loss of sight in one eye		
Any condition affecting both eyes, or the remaining eye only (not including short or long sight or colour blindness)		
Any condition affecting your visual field (the surrounding area you can see when looking directly ahead)		
Visual problems affecting either eye		
Any persistent limb problem for which your driving has to be restricted to certain types of vehicles or those with adapted controls		
Angina, other heart conditions or heart operation		
Any other condition that may affect driving. Please provide details below:		

If any of the above changes, I will inform the Fleet Compliance Team as soon as possible. I understand that I must also inform DVLA by writing to the: Drivers Medical Group, DVLA, Swansea SA99 1TU (the appropriate medical questionnaires can be downloaded from www.direct.gov.uk/driverhealth). Failure to do so is a criminal offence punishable by a fine of up to £1,000.

I have read and understood the medical requirements for hackney carriage and/or private hire driver licences and have been made aware of the latest version of the Wiltshire Council Guidelines for hackney carriage/private hire drivers, hackney carriage vehicles, private hire vehicles and private hire operators, these can be downloaded from our website at: <http://www.wiltshire.gov.uk/licences-permits-transport>.

I declare that the information contained in this document is true. I understand making a false declaration is a serious matter which can lead to a review of my hackney carriage and/or private hire driver licence, or in the case of a new applicant, refusal to grant a hackney carriage and/or private hire driver licence.

Print Name:			
Signature:		Date:	

**Medical Examination Form
for a hackney carriage/private hire drivers licence**

If this form is not fully completed we will return it to you and your application will be delayed.
For information about completing the form read the leaflet INF4D.
This is also available at www.gov.uk/reapply-driving-licence-medical-condition

Your details (applicant)

Name _____

Full address _____

Daytime phone number _____

Email address _____

Your doctor's details

Doctor's name Full address _____

Phone number _____ Email _____

You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.

**This report is valid for 6 months from the date the doctor and/or optician or optometrist signs it.
Please return it together with your application form.**

Examining doctor's details - to be completed by the doctor carrying out the examination.

Doctor's name _____

Full address _____

Phone number _____ Email _____

GMC registration number _____

**You must sign and date this form in Section 10. All black outlined boxes
MUST be answered. Please make sure all sections of the form have been completed.
The form will be returned to you if you don't do this.**

Medical examination report

Vision assessment

To be filled in by a doctor or optician/optometrist

If correction is needed to meet the eyesight standard for driving, all questions must be answered. If correction is not needed, questions 5 and 6 can be ignored.

1. Please confirm (✓) the scale you are using to express the driver's visual acuities.

Snellen Snellen expressed as a decimal
 LogMAR

2. Please state the visual acuity of each eye (see INF4D). 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	Corrected (using prescription worn for driving)
<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>

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** **No**

4. Were corrective lenses worn to meet this standard? **Yes** **No**
 If **Yes**, glasses contact lenses both together

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** **No**

6. If correction is worn for driving, is it well tolerated? **Yes** **No**
 If **No**, please give full details in the box provided

7. 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 formal visual field testing is considered necessary, DVLA will commission this at a later date

8. Is there diplopia? **Yes** **No**
 (a) If **Yes**, is it controlled?
 If **Yes**, please give full details in the box provided

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision? **Yes** **No**

10. Does the applicant have any other ophthalmic condition? **Yes** **No**
 If **Yes** to any of questions 7-10, please give full details in the box provided.

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature

E	D	M	M	Y	Y
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Please provide your GOC, HPC or GMC number

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Doctor/optometrist/optician's stamp

Applicant's full name

Date of birth

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Please do not detach this page

3 Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years? Yes No

If **No**, go to **section 4**

If **Yes**, please answer **all** questions below

1. Significant psychiatric disorder within the past 6 months? Yes No
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No
3. Dementia or cognitive impairment? Yes No
4. Persistent alcohol misuse in the past 12 months? Yes No
5. Alcohol dependence in the past 3 years? Yes No
6. Persistent drug misuse in the past 12 months? Yes No
7. Drug dependence in the past 3 years? Yes No

If 'Yes' to any questions above, please provide full details in section 6, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

4 Cardiac

a Coronary artery disease

Is there a history of, or evidence of, coronary artery disease? Yes No

If **No**, go to **section 4b**

If **Yes**, please answer **all** questions below and give details at **section 6** of the form and enclose relevant hospital notes.

1. Has the applicant suffered from angina? Yes No
If **Yes**, please give the date of the last known attack
2. Acute coronary syndrome including myocardial infarction? Yes No
If **Yes**, please give date
3. Coronary angioplasty (P.C.I.)? Yes No
If **Yes**, please give date of most recent intervention
4. Coronary artery by-pass graft surgery? Yes No
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? Yes No

b Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? Yes No

If **No**, go to **section 4c**

If **Yes**, please answer **all** questions below and give details in **section 6, page 6** and enclose relevant hospital notes.

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? Yes No
2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes No
3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted? Yes No
4. Has a pacemaker been implanted? Yes No
If **Yes**:
 - (a) Please give date of implantation
 - (b) Is the applicant free of the symptoms that caused the device to be fitted? Yes No
 - (c) Does the applicant attend a pacemaker clinic regularly? Yes No

c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection? Yes No

If **No**, go to **section 4d**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6**, and enclose relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease) Yes No
2. Does the applicant have claudication? Yes No
If **Yes**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?
Please give details
3. Aortic aneurysm? Yes No
If **Yes**:
 - (a) Site of aneurysm: Thoracic Abdominal
 - (b) Has it been repaired successfully? Yes No
 - (c) Is the transverse diameter **currently** > 5.5 cm? Yes NoIf **No**, please provide latest measurement and date obtained
4. Dissection of the aorta repaired successfully? Yes No
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? Yes No
If **Yes**, please provide relevant hospital notes

Applicant's full name

Date of birth

d Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? **Yes** **No**

If **No**, go to **section 4e**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6** and enclose relevant hospital notes.

- 1.** Is there a history of congenital heart disease? **Yes** **No**
- 2.** Is there a history of heart valve disease? **Yes** **No**
- 3.** Is there a history of aortic stenosis?
 If **Yes**, please provide relevant reports **Yes** **No**
- 4.** Is there any history of embolism?
 (not pulmonary embolism) **Yes** **No**
- 5.** Does the applicant currently have significant symptoms? **Yes** **No**
- 6.** Has there been any progression since the last licence application? (if relevant) **Yes** **No**

e Cardiac other

Is there a history of, or evidence of heart failure? **Yes** **No**

If **No**, go to **section 4f**

If **Yes**, please answer **all** questions and enclose relevant hospital notes.

- 1.** Established cardiomyopathy? **Yes** **No**
- 2.** Has a left ventricular assist device (LVAD) been implanted? **Yes** **No**
- 3.** A heart or heart/lung transplant? **Yes** **No**
- 4.** Untreated atrial myxoma? **Yes** **No**

f Blood pressure

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.

1. Please record today's **best** resting blood pressure reading

2. Is the applicant on anti-hypertensive treatment? **Yes** **No**

If **Yes**, please provide three previous readings with dates if available

<input type="text"/>					
<input type="text"/>					
<input type="text"/>					

g Cardiac investigations

Have any cardiac investigations been undertaken or planned? **Yes** **No**

If **No**, go to **section 5**

If **Yes**, please answer **all** questions **Yes** **No**

- 1.** 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 at **section 6, page 6**.

- 2.** Has an exercise ECG been undertaken (or planned)? **Yes** **No**

If **Yes**, please give date and give details in **section 6, page 6**

Please provide relevant reports if available

- 3.** Has an echocardiogram been undertaken (or planned)? **Yes** **No**

(a) If **Yes**, please give date and give details in **section 6, page 6**

(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?

Please provide relevant reports if available

- 4.** Has a coronary angiogram been undertaken (or planned)? **Yes** **No**

If **Yes**, please give date and give details in **section 6, page 6**.

Please provide relevant reports if available

- 5.** Has a 24 hour ECG tape been undertaken (or planned)? **Yes** **No**

If **Yes**, please give date and give details in **section 6, page 6**.

Please provide relevant reports if available

- 6.** Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? **Yes** **No**

If **Yes**, please give date and give details in **section 6, page 6**.

Please provide relevant reports if available

Applicant's full name

Date of birth

5 General

All questions must be answered. If Yes to any, give full details in section 6 and enclose relevant hospital notes.

1. Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive sleepiness? **Yes** **No**

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 than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 6.

- b) Please answer questions (i) – (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

(vi) Date of last review

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?
6. Does the applicant have a history of liver disease of any origin? **Yes** **No**
If **Yes**, please give details in **section 6**
7. Is there a history of renal failure? **Yes** **No**
If **Yes**, please give details in **section 6**
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 provide details of medication and symptoms in **section 6**
10. Does the applicant have any other medical condition that could affect safe driving? **Yes** **No**
If **Yes**, please provide details in **section 6**

6 Further details

Please forward copies of relevant hospital notes. Please do not send any notes not related to fitness to drive.

Applicant's full name

Date of birth

7**Consultants' details**

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

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

8**Medication**

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

Medication	Dosage
Reason for taking:	
Reason for taking:	
Reason for taking:	
Reason for taking:	
Reason for taking:	
Reason for taking:	

9**Additional information**

Patient's weight (kg)	<input type="text"/>
Height (cms)	<input type="text"/>
Details of smoking habits, if any	<input type="text"/>
Number of alcohol units taken each week	<input type="text"/>

10**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.

Signature of practitioner

Date of signature

Doctors stamp

Applicant's full name

Date of birth

This page must be completed by the applicant

Applicant's consent and declaration

This section MUST be filled in and must NOT be altered in any way.

Please read the following important information carefully then sign to confirm the statements below.

Important information about Consent

On occasion, as part of the investigation into your fitness to drive, the Taxi Licensing Authority may require you to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by the Taxi Licensing Authority. The membership of these panels conforms strictly to the principle of confidentiality.

Consent and Declaration

I authorise my Doctor(s) and Specialists(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Taxi Licensing Authority.

I authorise the Taxi Licensing Authority to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Paramedical staff and Panel members.

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.

I understand that it is a criminal offence if I make a false declaration to obtain a licence to drive taxis and private hire vehicles and can lead to prosecution.

Name _____

Signature _____ Date _____

I authorise Wiltshire Council to:-

Inform my Doctor(s) of the outcome of my case

Release reports to my Doctor(s)

YES	NO

Check List:

Have you signed and dated the consent and declaration and drivers declaration on page 2 of form

Have you checked that the report has been fully completed by the optician/doctor

YES	NO

**This report is valid for 6 months from the date the doctor and/or optician or optometrist signs it.
Please return it together with your application form.**

Medical Examination GP Declaration for a hackney carriage/private hire drivers licence

(This form must be attached to the completed D4 Wiltshire medical form)

To be completed by the GP carrying out the medical.

Medical Examination forms **will not** be accepted by the licensing authority for licensing purposes if this form has not been completed and attached to the D4 medical form, along with the HC/PH Driver Medical Fitness Declaration.

Failure to comply with the above will require the applicant to submit a further medical at a cost incurred by the applicant.

Please arrange for the patient to be examined.

Please complete the medical examination report. You are advised to consult DVLA's "At a Glance Guide to the current Medical Standards of Fitness to Drive" – Group 2 Entitlement. For further information, please refer to www.dft.gov.uk/dvla/medical/ataglance

Applicants who may be symptom free at the time of the examination must be advised that if, in future, they develop symptoms of a condition which could affect safe driving and they hold a hackney carriage or private hire driver's licence, they must inform the Licensing Officer at Wiltshire Council and the Driver's medical Group at DVLA.

Please ensure that you have completed all the sections and that the surgery practice "stamp" has been used where indicated.

Applicants Name:		Date of Birth:	
Telephone No:			
I have today examined the applicant for the purposes of establishing medical fitness to the DVLA Group 2 Entitlement. The medical form was signed in my presence by the applicant, and I have seen identification to verify their identity - passport/photo card driving licence/non – photo driving licence/ 2 proofs of address; In making this decision I have consulted the DVLA "At a Glance Guide to the current Medical Standards of Fitness to Drive", and consider that the applicant:			
Is fit to drive a licensed vehicle		Is not fit to drive a licensed vehicle	
If the applicant is under 65 years of age, do they have any medical condition that would require yearly monitoring under the DVLA's Group 2 Entitlement?			Yes
If answered Yes , please advise medical condition			No
Signature of Medical Practitioner			Date: