



1 Neurological disorders

Please tick ✓ the appropriate boxes
Does the applicant have a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)?
If no, go to section 2, Diabetes mellitus
If yes, please answer all questions below.

- | | | |
|--|------------------------------|-----------------------------|
| | Yes | No |
| 1. Has the applicant had any form of seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) Has the applicant had more than one seizure episode? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Please give date of first and last episode. | | |
| First episode | DDMMYY | |
| Last episode | DDMMYY | |
| (c) Is the applicant currently on anti-seizure medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) If no longer treated, when did treatment end? | DDMMYY | |
| (e) Has the applicant had a brain scan?
If yes, please give details in section 9, page 6. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has the applicant experienced any dissociative/functional seizures? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (a) If yes, please give date of most recent episode. | DDMMYY | |
| (b) If yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Stroke or TIA? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, give date. | DDMMYY | |
| (a) Has there been a full recovery? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Has a carotid ultrasound been undertaken? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) If yes, was the carotid artery stenosis >50% in either carotid artery? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Is there a history of multiple strokes/TIAs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Subarachnoid haemorrhage (non-traumatic)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Significant head injury within the last 10 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Any form of brain tumour? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Other intracranial pathology? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Chronic neurological disorder(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Parkinson's disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Blackout, impaired consciousness or loss of awareness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |

2 Diabetes mellitus

- | | | |
|--|------------------------------|-----------------------------|
| | Yes | No |
| Does the applicant have diabetes mellitus? | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, go to section 3, Cardiac | | |
| If yes, please answer all questions below. | | |
| 1. Is the diabetes treated by: | Yes | No |
| (a) Insulin? | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, go to 1c | | |
| If yes, please give date started on insulin. | DDMMYY | |
| (b) Are there at least 4 continuous weeks of glucose readings stored on a memory meter or meters? | <input type="checkbox"/> | <input type="checkbox"/> |
| If no, please give details in section 9, page 6. | | |
| (c) Other injectable treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) A Sulphonylurea or a Glinide? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Oral hypoglycaemic agents and diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Diet only? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. (a) Does the applicant monitor their glucose level using continuous glucose monitoring (CGM)? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) If yes, is the continuous glucose monitoring (CGM) device approved for non-adjunctive use? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Does the applicant carry a finger prick monitoring device? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Does the applicant test glucose at least twice every day? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Does the applicant test glucose at times relevant to driving? (Within 2 hours of starting their first journey of the day and continuing to check at least every 2 hours during their journey. There must be no more than 2 hours between glucose checks at any time during their journey). | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Does the applicant keep fast-acting carbohydrate within easy reach whilst driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. (a) Has the applicant ever had a hypoglycaemic episode? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Is there full awareness of hypoglycaemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, please give details and dates below. | | |
| | [Text box] | |
| | DDMMYY | DDMMYY |
| | DDMMYY | |
| 5. Has there been laser treatment or intra-vitreous treatment for retinopathy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, please give most recent date of treatment. | DDMMYY | |

Applicant's full name	[Grid]	Date of birth	DDMMYY
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3 Cardiac

a Coronary artery disease

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

If no, go to section 3b, Cardiac arrhythmia

If yes, please answer all questions below.

1. Has the applicant ever had an episode of 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 (PCI)? Yes No

If yes, please give date of most recent intervention.

4. Coronary artery bypass graft surgery? Yes No

If yes, please give date.

5. If yes to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details below. Yes No

b Cardiac arrhythmia

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

If no, go to section 3c, Peripheral arterial disease

If yes, please answer all questions below.

1. Has there been a significant disturbance of cardiac rhythm causing/likely to cause incapacity 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 (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes No

4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) 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?

(c) Does the applicant attend a pacemaker clinic regularly?

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

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

If no, go to section 3d, Valvular/congenital heart disease

If yes, please answer all questions below.

1. Peripheral arterial disease? (excluding Buerger's disease) Yes No

2. Does the applicant have claudication? Yes No

 If yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT?

3. Aortic aneurysm? Yes No
 If yes:

(a) Site of aneurysm: Thoracic
 Abdominal

(b) Has it been repaired successfully?

(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.

. cm

4. (a) Dissection of aorta? Yes No

(b) If yes, has the dissection been successfully repaired?

If yes to 4a, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? Yes No

(a) If yes, are there any associated risk factors*?

*risk factors include –

- family history of aortic dissection
- greater than 3mm per year increase than aneurysm diameter
- pregnancy

d Valvular/congenital heart disease

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

If no, go to section 3e, Cardiac other

If yes, please answer all questions below.

1. Is there a history of congenital heart disease? Yes No

2. Is there a history of heart valve disease? Yes No

(a) If yes, are they symptomatic?

3. Is there a history of aortic stenosis? Yes No
 If yes, please provide relevant reports (including echocardiogram).

4. Has there been any progression (either clinically or on scans etc) since the last licence application? Yes No

Applicant's full name

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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 below.

1. Please provide the NYHA class, if known.

2. Established cardiomyopathy? Yes No

If yes, please give details in section 9, page 6.

3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No

4. A heart or heart/lung transplant? Yes No

5. Evidence or history of pulmonary arterial hypertension? 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

1. Brugada syndrome? Yes No

2. Long QT syndrome? Yes No
If yes to either, please give details in section 9, page 6.

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.

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

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 5.

1. Is there a history of the following: Yes No

(a) left bundle branch block (LBBB)?

(b) right bundle branch block (RBBB)?

(c) paced rhythm?

If yes to (a), (b) or (c), please give details in section 9, page 6.

Note: If yes to questions 2 to 5, please give dates in the boxes provided, give details in section 9, page 6.

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

3. 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%?

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

5. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Yes No

4 Psychiatric illness

Is there any significant mental illness or cognitive impairment likely to affect safe driving? Yes No

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. Yes No

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No

3. (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.

1. Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? Yes No

2. If there is a history of an alcohol use disorder, has this been associated with any of the following features which indicate a physiological dependence on alcohol: Yes No

(a) Required medical assisted withdrawal?

Date treatment ended:

(b) Alcohol withdrawal seizure?

Date of last event:

3. Based on their clinical record and/or account of drinking provided to you, is their alcohol consumption:

(a) Abstinent? Yes No Don't know

If yes, for how long:

(b) Controlled? Yes No Don't know

If yes, for how long:

4. 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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11 Examining doctor's signature and stamp

To be filled in by the doctor carrying out the examination.

Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this.

I confirm that this report was filled in by me at examination and I have taken the applicant's history into account. I also confirm that I am currently GMC registered and licensed to practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK.

Being a registered medical practitioner who has examined the applicant and have had access to at least a summary of their medical records, and with due regard to the advice and guidance appertaining to Group 2 drivers issued by the DVLA, I consider the applicant:

HAS met the DVLA Group 2 medical standards and is therefore fit to hold a hackney carriage/ private hire driver's licence.

Has NOT met DVLA Group 2 medical standards and is therefore unfit to hold a hackney carriage / private hire driver's licence.

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 relevant details

Signature of examining doctor

Date of signature

Doctor's stamp

The applicant must fill in this Applicant's declaration

Name

Signature

Date

I authorise the Licensing authority to correspond with medical professionals via electronic channels (email)

Yes No

Checklist

- Have you signed and dated the declaration? Yes
- Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed? Yes

Important

This report is valid for 3 months from the date the doctor, optician or optometrist signs it.