

Medical Assessment Report Form

LOCAL GOVERNMENT (MISCELLANEOUS PROVISIONS) ACT 1976



Information Notes

It is a requirement under section 57 of the Local Government (Miscellaneous Provisions) Act 1976 to provide a Medical Assessment Report to state that you are physically fit to drive a Hackney Carriage or Private Hire vehicle.

This form is to be completed by a Cambridge City Council approved Practitioner and is for the strict confidential use of the Licensing Authority (Cambridge City Council).

Any fee charged for the medical assessment is payable by the applicant.

A medical assessment is required for:

- All new Private Hire, Hackney Carriage and Dual Driver applicants (unless they hold a current HGV or PSV licence, in which case it will not be necessary for these applicants to have a further medical providing that they have the Class 2 Provisional Medical entitlement placed on to their DVLA Licence.
- All licensed drivers at the age of 45, and every five years thereafter.
- All licensed drivers at the age of 65, and annually thereafter.
- Any licensed driver who is diagnosed with a medical condition which may affect his/ her driving ability at any time where the Council, GP or Designated Medical Practitioner requires a more frequent check than prescribed above.

Cambridge City Council will NOT accept a medical assessment certificate if it is more than 1 month old.

Please complete in BLOCK CAPITALS AND BLACK INK.

1. APPLICANT DETAILS

TITLE (✓ as appropriate): Mr Mrs Miss Ms Other (please state):

FORENAMES:

SURNAME:

CURRENT ADDRESS:

POST CODE:

CONTACT NUMBER:

DATE OF BIRTH:

AGE:

2. APPLICANT CONSENT AND DECLARATION (please read the following carefully before signing and dating the declaration)

I authorise my General Practitioner(s) and, where appropriate, Specialist(s) to release medical information relating to myself and any pertinent conditions together with any other relevant information relating to my fitness to drive, to the Licensing & Enforcement Team of Cambridge City Council for the purpose of the Council (by its Authorised Officers and/ or Members) of assessing my fitness to drive a Hackney Carriage and/ or Private Hire Vehicle licensed by the Council.

I declare that to the best of my knowledge and belief all information given by me to the approved medical practitioner in connection with the assessment and completion of the DVLA Group II medical assessment report form are true.

Signed: _____ Dated: □□ / / □□□□

THE FOLLOWING SECTIONS BELOW ARE FOR COMPLETION BY THE APPROVED MEDICAL PRACTITIONER COMPLETING THE MEDICAL ASSESSMENT.

3a. Is the applicant a registered patient of the surgery/ medical centre at which you practice as a registered medical practitioner?

YES

NO

3b. Have you reviewed the above applicant's medical records?

YES

NO

If reviewing a print out of the medical records, please give the date of the printout:

ASSESSMENT

A	VISION ASSESSMENT (*please refer to guidance notes at the end of this document)
	The visual acuity, as measured by the 6 metre Snellen chart must be at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and at least Snellen 6/60 (decimal Snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to achieve this standard. A LogMAR reading is acceptable (corrective lenses may be worn).
1.	Please confirm (✓ as appropriate) 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:
	Uncorrected LEFT: RIGHT:
	Corrected (using the prescription worn for driving): LEFT: RIGHT

3.	Please give the best binocular acuity with corrective lenses if worn for driving
4.	<p>If glasses were worn, was the distance spectacle prescription if either lens used of a corrective power greater than plus 8 (+8) dioptres?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
5.	<p>If correction is worn for driving, is it well tolerated?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
6.	<p>a) Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/ or peripheral)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>b) Correction well tolerated?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
7.	Please state the visual acuity of each eye:
	<p>Uncorrected</p> <p>LEFT:</p> <p>RIGHT:</p>
	<p>Corrected (using the prescription worn for driving):</p> <p>LEFT:</p> <p>RIGHT:</p>
8.	<p>Is there a defect in the patient's binocular field of vision (central and/ or peripheral)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
9.	<p>Is there a diplopia (controlled or uncontrolled)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
10.	<p>Does the patient have any other ophthalmic condition?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
If YES to questions 4, 5 or 6 please give details in Section N.	
11	<p>In relation to Section A does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

B	NERVOUS SYSTEM
1	<p>Has the patient had any form of epileptic attack?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please complete questions a-f below:</p>
a)	<p>Has the patient had more than one attack?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
b)	<p>Please detail the date of the 1st attack:</p> <p>Please detail the date of the 2nd attack:</p>
c)	<p>Is the patient currently on any anti-epilepsy medication?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give details of the current medication:</p>
d)	<p>If treated, please give the date when the treatment ended:</p>
e)	<p>Has the patient had a brain scan?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give dates and state whether an MRI scan or CT scan:</p>
f)	<p>Has the patient had an EEG?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide the date and details:</p>
2	<p>Is there a history of blackout or impaired consciousness within the last five years?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If YES please give details in Section N.</p>
3	<p>Is there a history of, or evidence of, a stroke or TIA?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give the date and details:</p> <p>Has there been a full recovery?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>

<p>4</p>	<p>Has there been a history of, or evidence of, sudden and disabling dizziness or vertigo within the last one year with a liability to recur?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give dates and details:</p>
<p>5</p>	<p>Has there been a history of, or evidence of, a subarachnoid haemorrhage?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give dates and details:</p>
<p>6</p>	<p>Has there been a history of, or evidence of, serious head injury within the last 10 years?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give dates and details:</p>
<p>7</p>	<p>Has there been a history of, or evidence of, a brain tumour (benign or malignant, primary or secondary)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give dates and details:</p>
<p>8</p>	<p>Has there been a history of, or evidence of other brain surgery or abnormality?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give dates and details:</p>
<p>9</p>	<p>Has there been a history of, or evidence of, any chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give dates and details:</p>
<p>10</p>	<p>In relation to Section B does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

C	DIABETES MELLITUS	
1	Does the patient have diabetes mellitus? YES <input type="checkbox"/>	NO <input type="checkbox"/>
If yes, please complete the questions below:		
2	Is the diabetes managed by Insulin? YES <input type="checkbox"/>	NO <input type="checkbox"/>
If yes, please give the date the patient started on Insulin:		
3	Is the diabetes managed by Exenatide/ Byetta? YES <input type="checkbox"/>	NO <input type="checkbox"/>
4	Is the diabetes managed by oral hypoglycaemic agents and diet? YES <input type="checkbox"/>	NO <input type="checkbox"/>
If yes, please provide details of medication:		
5	Is the diabetes managed by diet only? YES <input type="checkbox"/>	NO <input type="checkbox"/>
6	Is there evidence of loss of visual field? YES <input type="checkbox"/>	NO <input type="checkbox"/>
7	Is there evidence of severe peripheral neuropathy, sufficient to impair limb function for safe driving? YES <input type="checkbox"/>	NO <input type="checkbox"/>
8	Is there evidence of diminished/ absent awareness or hypoglycaemia? YES <input type="checkbox"/>	NO <input type="checkbox"/>
9	Has there been any laser treatment for retinopathy? YES <input type="checkbox"/>	NO <input type="checkbox"/>
if yes, please give date(s) of treatment:		
10	Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance? YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES to questions 6 - 10 please give details in Section N.		
11	In relation to Section C does the applicant meet the DVLA Group II Medical Conditions? YES <input type="checkbox"/>	
If no, please indicate reasons why:		

D	PSYCHIATRIC ILLNESS
1	Is there a history of, or evidence of, a significant psychiatric disorder within the past 6 months? YES <input type="checkbox"/> NO <input type="checkbox"/>
2	Is there a history of, or evidence of, a psychotic illness within the past 3 years, including psychotic depression? YES <input type="checkbox"/> NO <input type="checkbox"/>
3	Is there a history of, or evidence of, dementia or cognitive impairment? YES <input type="checkbox"/> NO <input type="checkbox"/>
4	Is there a history of, or evidence of, persistent alcohol misuse in the past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/>
5	Is there a history of, or evidence of, alcohol dependency in the past 3 years? YES <input type="checkbox"/> NO <input type="checkbox"/>
6	Is there a history of, or evidence of, persistent drug misuse in the past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/>
7	Is there a history of, or evidence of, drug dependency in the past 3 years? YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES to questions 1 - 7 please give details of date(s), prognosis, period of stability and details of medication, dosage and any side effects in Section N. If the patient remains under specialist clinic(s) please give details in Section N.	
8	In relation to Section D does the applicant meet the DVLA Group II Medical Conditions? YES <input type="checkbox"/> NO <input type="checkbox"/> If no, please indicate reasons why:

E	CARDIAC
1	Is there a history of, or evidence of, coronary artery disease? YES <input type="checkbox"/> NO <input type="checkbox"/>
2	Is there a history of, or evidence of, any acute coronary syndromes, including myocardial infarction? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please give dates:
3	Is there a history of, or evidence of, coronary artery bypass graft surgery? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please give dates:

4	<p>Is there a history of, or evidence of, coronary angioplasty?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give the date of the most recent intervention:</p>
5	<p>Has the patient suffered from Angina?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide date of last attack:</p>
If YES to questions 1 - 5 please give details in Section N.	
6	<p>In relation to Section E does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

F	CARDIAC ARRHYTHMIA
1	<p>Is there a history of, or evidence of, cardiac arrhythmia?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
2	<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 the last 5 years?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
3	<p>Has the arrhythmia been controlled satisfactorily for at least 3 months?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
4	<p>Has an ICD or biventricular pacemaker been implanted?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
5	<p>Has a pacemaker been implanted?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give the date:</p> <p>Is the patient free of symptoms that caused the device to be fitted?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Does the patient attend a pacemaker clinic regularly?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
If YES to questions 1 - 5 please give details in Section N.	

6	<p>In relation to Section F does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>
----------	---

G	PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/ DISSECTION
1	<p>Is there a history of, or evidence of, Peripheral arterial disease (excluding Buerger's Disease)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
2	<p>Does the patient have claudication?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give details as to how long in minutes the patient can walk at a brisk pace before being symptom limited:</p>
3	<p>Is there history of an aortic aneurysm?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Site of aneurysm:</p> <p>Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/></p> <p>Has it been repaired successfully?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Is the transverse diameter currently >5.5cms?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please provide the latest measurement:</p> <p>Date obtained:</p> <p>Has dissection of the aorta repaired successfully?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please provide details:</p>
	<p>If YES to questions 1 – 3 please give details in Section N.</p>

4	<p>In relation to Section G does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>
----------	---

H	VALVULAR/ CONGENITAL HEART DISEASE
1	<p>Is there a history of, or evidence of, valvular/ congenital heart disease?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
2	<p>Is there a history of congenital heart disorder?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
3	<p>Is there a history of heart valve disease?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
4	<p>Is there a history of embolism (not pulmonary embolism)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
5	<p>Does the patient currently have significant symptoms?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
6	<p>Has there been any progression since the last licence application?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
	<p>If YES to questions 1 – 6 please give details in Section N.</p>
7	<p>In relation to Section H does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

I CARDIAC OTHER	
1	Does the patient have a history of, or evidence of, heart failure? YES <input type="checkbox"/> NO <input type="checkbox"/>
2	Does the patient have a history of, or evidence of, established cardiomyopathy? YES <input type="checkbox"/> NO <input type="checkbox"/>
3	Does the patient have a history of, or evidence of, a heart or heart/lung transplant? YES <input type="checkbox"/> NO <input type="checkbox"/>
If YES to questions 1 – 3 please give details in Section N.	
4	In relation to Section I does the applicant meet the DVLA Group II Medical Conditions? YES <input type="checkbox"/> NO <input type="checkbox"/> If no, please indicate reasons why:

J CARDIAC INVESTIGATIONS	
1	Has a resting ECG been undertaken? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, does it show: Pathological Q Waves YES <input type="checkbox"/> NO <input type="checkbox"/> Left bundle branch block YES <input type="checkbox"/> NO <input type="checkbox"/> Right bundle branch block YES <input type="checkbox"/> NO <input type="checkbox"/>
2	Has the exercise ECG been undertaken (or planned)? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please provide date:

3	<p>Has an echocardiogram been undertaken (or planned)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide date:</p> <p>If undertaken, is/ was the left ventricular ejection fraction greater than, or equal to 40%?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
4	<p>Has a coronary angiogram been undertaken (or planned)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide date:</p>
5	<p>Has a 24 hour ECG tape been undertaken (or planned)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide date:</p>
6	<p>Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide date:</p>
If YES to questions 2 - 6 please give details in Section N.	
7	<p>In relation to Section J does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

K	BLOOD PRESSURE
1	<p>Is today's best systolic pressure reading 180mm Hg or more?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give reading:</p>

2	<p>Is today's best diastolic pressure reading 100mm Hg or more?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Please give reading:</p>
3	<p>Is the patient on anti-hypertensive treatment?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide three previous readings with dates if available:</p> <p>1. Reading = _____ Date: _____</p> <p>2. Reading = _____ Date: _____</p> <p>3. Reading = _____ Date: _____</p>
4	<p>In relation to Section K does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

L	GENERAL
1	<p>Is there currently a disability of the spine or limbs likely to impair control of the vehicle?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
2	<p>Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give dates and diagnosis and state whether there is current evidence of dissemination:</p>
3	<p>Is there any evidence the patient has cancer that causes fatigue or cachexia that affects safe driving?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
4	<p>Is the patient profoundly deaf?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, is the patient able to communicate in the event of an emergency by speech or by using a device?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>

5	<p>Is there a history of either renal or hepatic failure?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
6	<p>Is there a history of, or evidence of sleep apnoea syndrome?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide details:</p> <p>Date of diagnosis:</p> <p>Is it controlled successfully?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please state treatment:</p> <p>Please state period of control:</p> <p>Please provide neck circumference:</p> <p>Please provide girth measurement in cms:</p> <p>Date last seen by consultant:</p>
7	<p>Does the patient suffer from narcolepsy/ cataplexy?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
8	<p>Is there any other medical condition causing daytime sleepiness?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide details:</p> <p>Date of diagnosis:</p> <p>Is it controlled successfully?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please state treatment:</p> <p>Please state period of control:</p> <p>Date last seen by consultant:</p>
9	<p>Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p>
10	<p>Does any medication currently taken cause the patient side effects that could affect safe driving?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide details:</p>

11	<p>Does the patient have any other medical condition that could affect safe driving?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please provide details:</p>
12	<p>In relation to Section L does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

M	ALCOHOL AND/ OR DRUG MISUSE
1	<p>Does the patient show any evidence of being addicted to the excessive use of alcohol?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give details:</p>
2	<p>Does the patient show any evidence of being addicted to the excessive use of alcohol?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If yes, please give details:</p>
	<p>If YES to questions 1 - 2 please give details in Section N.</p>
3	<p>In relation to Section M does the applicant meet the DVLA Group II Medical Conditions?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>If no, please indicate reasons why:</p>

N	ADDITIONAL INFORMATION

GUIDANCE NOTE

Confirming identity

Please ensure that you confirm the applicant's identity before examination.

Examining the applicant

- You must examine the applicant fully and complete all sections of the medical assessment.
- Please obtain details of the applicant's medical history when you complete the report.
- Any amendments must be dated and signed.
- Details of any medical condition not mentioned on the form must be included in section N.

Vision assessment

As the visual standards require a higher level of response from doctors, we advise GPs to refer patients requesting certification to optometrists for the vision section of the assessment, unless the patient has either 6/6 vision uncorrected or 6/6 vision corrected and with recent evidence of prescription strength."

Only complete the vision assessment if you are able to fully and accurately complete all the questions. If you are unable to do this you must advise the applicant of this and the need for them to arrange to have this part of the assessment completed by an optician or optometrist.

- **You must be able to confirm the strength of glasses (dioptries) from a prescription.**
- **You must be able to measure the applicant's visual acuity to at least 6/7.5 (decimal 0.8) of a Snellen chart** (you may need to purchase a new Snellen Chart in order to do this).
- You must convert any 3 metre readings to the 6 metre equivalent.
- You must confirm which measurement scale has been used on the D4 medical examination report.
- We will also accept the LogMAR equivalent.
- We cannot accept a Snellen reading shown with a plus(+) or minus(-) e.g. 6/6-2 or 6/9+3.
- We have advised the applicant that if they wear glasses to meet the required eyesight standard for driving they must bring their current prescription to the assessment.
- **If an applicant does not need glasses for driving or they use contact lenses or if they have a minus (-) dioptre prescription, question 5 of the vision assessment can be answered "No".**
- Both examinations must have taken place and have been signed and dated by the doctor and optician/optometrist no more than 4 months before the date the application is received by DVLA.
- The eyesight examination must be undertaken using the correction currently worn for driving. However, if the prescription has not changed and the acuity standards can be met, the prescription does not need to have been dated within the last 4 months.

DECLARATION AND CERTIFICATION OF FITNESS TO DRIVE

I certify that I am familiar with the current requirements of Group II 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 Vehicle under the DVLA Group II Medical Standards.

I certify that the applicant is (✓ as appropriate):

FIT

UNFIT

to act as the driver of a Hackney Carriage or Private Hire Vehicle.

DOCTOR'S NAME:

SURGERY NAME & ADDRESS:

SIGNED:

DATE:

SURGERY STAMP: