SOUTH RIBBLE BOROUGH COUNCIL - LICENSING UNIT
CIVIC CENTRE WEST PADDOCK LEYLAND PR25 1DH

Hackney Carriage / Private Hire GROUP II MEDICAL EXAMINATION REPORT FORM

INFORMATION NOTES

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act, 1976, to provide a Medical Examination Report to the effect that you are physically fit to drive a Hackney Carriage / Private Hire vehicle.

This form is to be completed by the applicant's own General Practitioner (GP) or any other doctor with FULL ACCESS to applicant's medical records and is for the confidential use of the Licensing Authority.

A Group II Medical Report Form is required every 5 years until the age of 65.
From the age of 65, each renewal application must be accompanied by a Group II Medical Report Form.

Any fee charged by the GP / Doctor is payable by the applicant.

• Please use this form to record medical examination details

• Please complete in block capital letters and in black ink

Licensing Officers are not permitted to complete or amend forms on behalf of applicants for legal reasons.

Please return this form once fully completed to:

South Ribble Borough Council - Licensing Unit
Civic Centre
West Paddock
Leyland
PR25 1DH

The Licensing Section is committed to an accessible public transport system in which all members of society have the same opportunity to travel. Taxis and Private Hire vehicles are a vital link in the transport chain and it is important that people who use them have confidence that drivers will accept them and transport them in safety and reasonable comfort, providing assistance as may be reasonably required.

Full name of Applicant: …… **DOB:**.....

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Guidance Notes

WHAT YOU HAVE TO DO:

1. Before consulting your GP please read the notes 'Medical standards for drivers of passenger carrying vehicles', below.

2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your GP/Optician before you arrange for this medical form to be completed as your GP will normally charge you for completing it. In the event of your application being refused, the fee you pay your GP is not refundable. South Ribble Borough Council has no responsibility for the fee payable to your GP.

3. Fill in Section 9 and 10 of this report in the presence of the GP carrying out the examination as well as at the top of each page of this form.

4. Application forms must be submitted together with the Group II Medical Report Form otherwise there may be delays in processing your application.

WHAT THE GP HAS TO DO:

1. Arrange for the patient to be seen and examined.

2. Complete Sections 1-8 of this report. You may find it helpful to consult the DVLAs "At a Glance" booklet. This is available for download at the 'medical rules for all drivers' Section of www.gov.uk/browse/driving

3. Applicants who may be asymptomatic at the time of the examination should be advised that, if in future they develop symptoms of a condition which could affect safe driving and they hold either a Hackney Carriage and / or Private Hire driver licence **they must inform** the Licensing Section at Civic Centre, West Paddock Leyland PR25 1DH.

4. Please ensure that you have completed all Sections within this form. If this report does not bring out important clinical details with respect to driving, please give details in Section 7.

MEDICAL STANDARDS FOR DRIVERS OF PASSENGER CARRYING VEHICLES:

Medical standards for drivers of passenger carrying vehicles are higher than those required for car drivers. The following conditions are likely to be a bar to the holding of a Hackney Carriage/ Private Hire driver licence:

1. Epileptic Attack
Applicants must have been free of epileptic seizures for at least the last ten years and have not taken anti-epileptic medication during this ten year period. The Licensing Section are likely to refuse or revoke the licence if these conditions cannot be met.

2. Diabetes
Insulin treated diabetics licensed before 1 April 1991 are dealt with individually and licensing is subject to satisfactory annual consultant medical certification and to the proviso that they are not suffering from any other relevant disabilities. Since 1 April 1991 diabetic patients on insulin are barred from first applying for a passenger carrying vehicle driving licence and from renewing thereafter unless they can meet the criteria of Appendix C1.

3. Eyesight
All applicants must be able to read in good daylight a number plate at 20.5 metres (67 feet) and, if glasses or corrective lenses are required to do so, these must be worn while driving.
In addition applicants must have:
• A visual acuity of at least 6/9 in the better eye
• A visual acuity of at least 6/12 in the worse eye
• If these are achieved by correction the uncorrected visual acuity in each eye must be no less than 3/60

Applicants are also barred from holding a licence if they have:
• Uncontrolled diplopia (double vision)
• Or do not have a normal binocular field of vision

Full name of Applicant: …… **DOB:**.....

4. Other medical conditions
In addition applicants and renewals are likely to be refused if they are unable to meet the national recommended guidelines in the following cases:

- Within three months of myocardial infarction, any episode of unstable angina, CABG or coronary angioplasty
- A significant disturbance of cardiac rhythm occurring within the past five years unless special criteria are met
- Suffering from or receiving medication for angina or heart failure
- Hypertension where the BP is persistently 180+ Systolic OR 100+ Diastolic.
- A stroke or TIA within the last twelve months
- Unexplained loss of consciousness within the past five years
- Meniere's and other conditions causing disabling vertigo, within the past twelve months and with a liability to recurrence
- Recent severe head injury with serious continuing after effects or major brain surgery
- Parkinson's disease, multiple sclerosis or other "chronic" neurological disorders likely to affect limb power and co-ordination
- Suffering from a psychotic illness in the past three years or suffering from dementia
- Alcohol dependency or misuse or persistent drug or substance misuse or dependency in the past three years
- Insuperable difficulty in communicating by telephone in an emergency
- Any other serious medical condition which may cause problems for road safety when driving a passenger carrying vehicle
- If major psychotropic or neuroleptic medication is being taken
- Any malignant condition within the last two years likely to metastasise to the brain

C1 CRITERIA FOR INSULIN DEPENDENT DRIVERS

Recent regulation changes allow insulin dependent drivers to apply for, or renew, their entitlement to drive a Private Hire and/ or Hackney Carriage vehicle, subject to them meeting all the 'qualifying conditions'.

The qualifying conditions that must be met when applicants apply are as follows:

1. They must have had no hypoglycaemic attacks requiring assistance whilst driving within the previous 12 months.
2. They will not be able to apply until their condition has been stable for a period of a least one month.
3. They must regularly monitor their condition by checking their blood glucose levels at least twice daily and at times relevant to driving. DVLA advise the use of a memory chip meter for such monitoring.
4. They must arrange to be examined every 12 months by a hospital consultant, who specialises in diabetes. At the examination the consultation will require sight of their blood glucose records for the last 3 months.
5. They must have no other condition, which would render them a danger when driving this type of vehicle.
6. They will be required to sign an undertaking to comply with the directions of doctors treating the diabetes and to report immediately to DVLA any significant change to their condition.

At a meeting of the Secretary of State for Transport's Honorary Medical Advisory Panel on Driving and Diabetes Mellitus, the Panel was made aware that some licensing authorities were permitting drivers with insulin treated diabetes to be issued with taxi licences. The Panel was of the view that the group 2 medical was still the best practice standard for drivers, but that it would be reasonable for licensing authorities to accept the C1 criteria above should they wish to do so.

Full name of Applicant: …… **DOB:**.....

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MEDICAL EXAMINATION REPORT

Please give patient's weight (kg/st)		Height (cms/ft)	

Please give details of smoking habits, if any	
Please give number of alcohol units taken each week	

Is the urine analysis positive for Glucose? No ☐ Yes ☐ (please tick appropriate box)

Details of specialist(s)/ consultants, including addresses	1.	2.	3.
Speciality			
Date last seen			
Current medication including exact dosage and reason for each treatment			

Date when first licensed to drive a taxi/PH vehicle DD MM YY And/or lorry DD MM YY And/or bus DD MM YY

1 Vision

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.

You MUST answer ALL the following questions

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

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

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2. Please state the visual acuity of each eye.

	UNCORRECTED		**CORRECTED (using the prescription worn for driving)**	
Right		Left	Right	Left

3. Please give the best binocular acuity with corrective lenses if worn for driving.

Please tick ✓ the appropriate boxes	**YES**	**NO**
4. If glasses were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptres?	☐	☐
5. If a correction is worn for driving, is it well tolerated?	☐	☐

If you answer Yes to ANY of the following, give details in the box provided.

6. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)?	☐	☐
7. Is there diplopia?	☐	☐
(a) Is it controlled?	☐	☐

If **Yes**, please ensure you give full details in the box provided.

8. Is there any reason to believe that there is impairment of contrast sensitivity or intolerance to glare?	☐	☐
9. Does the applicant have any other ophthalmic condition?	☐	☐

Details

Name and signature of professional carrying out Vision Assessment:

Name (print)

Signature **Date**

Full name of Applicant: …… **DOB:**.....

2 Nervous System

Please tick ✓ the appropriate boxes YES NO

1. Has the applicant had any form of seizure? ☐ ☐
If **NO**, please go to **question 2**
If **YES**, please answer questions a-f

(a) Has the applicant had more than one attack? ☐ ☐

(b) If Yes, please give date of first and last attack

	D D	M M	Y Y
First			
Last			

(c) Is the applicant currently on anti-epilepsy medication? ☐ ☐
If **YES,** please complete current medication on the appropriate section at the front of this form

(d) If no longer treated, please give date when treatment ended

D D	M M	Y Y

(e) Has the applicant had a brain scan? If **YES**, please state:

MRI

D D	M M	Y Y

CT

D D	M M	Y Y

(f) Has the patient had an EEG?

D D	M M	Y Y

If **YES** to any of the above, please supply reports if available.

2. Is there a history of blackout or impaired consciousness within the last 5 years? ☐ ☐
If **YES,** please give date(s) and details in **Section 7**

3. Does the applicant suffer from narcolepsy or cataplexy? ☐ ☐
If **YES,** please give date(s) and details in **Section 7**

4. Is there a history of, or evidence of **ANY** conditions listed at a-h below**?** ☐ ☐
If NO, go to **Section 3.**
If YES, please tick the relevant box(es) and give dates and full details at **Section 7** and supply any relevant reports.

(a) Stroke or TIA ☐
If **YES**, please give date

D D	M M	Y Y

Has there been a **full** recovery? ☐ ☐

(b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur ☐

(c) Subarachnoid haemorrhage ☐

(d) Serious traumatic brain injury within the last 10 years ☐

(e) Any form of brain tumour ☐

(f) Other brain surgery or abnormality ☐

(g) Chronic neurological disorders ☐

(h) Parkinson's disease ☐

Full name of Applicant: …… **DOB:**……

3 Diabetes Mellitus

Please tick ✓ the appropriate boxes	**YES**	**NO**
1. Does the applicant have diabetes mellitus? If **NO**, please go to **Section 4** If **YES,** please answer the following questions.	☐	☐
2. Is the diabetes managed by:- (a) Insulin?	☐	☐
If **YES**, please give date started on insulin — DD / MM / YY		
(b) If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter(s)?	☐	☐
If **NO**, please give details in **Section 7.**		
(c) Other injectable treatments?	☐	☐
(d) A Sulphonylurea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents and diet? If **YES** to any of a-e, please complete current medication on the appropriate section on the front of this form	☐	☐
(f) Diet only?	☐	☐
3. (a) Does the applicant test blood glucose at least twice every day?	☐	☐
(b) Does the patient test at times relevant to driving?	☐	☐
(c) Does the patient carry fast acting carbohydrate within easy reach when driving?	☐	☐
(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐
4. Is there any evidence of impaired awareness of hypoglycaemia?	☐	☐
5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	☐	☐
6. Is there evidence of:- (a) Loss of visual field?	☐	☐
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	☐	☐
If **YES** to any of 4-6 above, please give details in **Section 7**		
7. Has there been laser treatment or intra-vitreal treatment for retinopathy?	☐	☐
If **YES,** please give date(s) of treatment		

4 Psychiatric Illness

Please tick ✓ the appropriate boxes	**YES**	**NO**
Is there a history of, or evidence of, ANY of the conditions listed at 1-7 below?	☐	☐
If **NO**, go to **Section 5**		
If YES, please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7.** **NB.** Please enclose relevant hospital notes.		

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NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1.

1. Significant psychiatric disorder within the past 6 months ☐

2. Psychosis or hypomania/mania within the past 3 years, including psychotic depression ☐

3. Dementia or cognitive impairment ☐

4. Persistent alcohol misuse in the past 12 months ☐

5. Alcohol dependence in the past 3 years ☐

6. Persistent drug misuse in the past 12 months ☐

7. Drug dependency in the past 3 years ☐

5 Cardiac

Please follow the instructions in all sections (5A-5G) giving details as required in Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed.

5A Coronary artery disease

Please tick ✓ the appropriate boxes		**YES**	**NO**
Is there a history of, or evidence of, coronary artery disease? If **NO**, go to **Section 5B** **If YES** please answer all questions below and give details at **Section 7** of the form.		☐	☐
1. Has the applicant suffered from Angina? If **YES**, please give the date of the last known attack	D D M M Y Y	☐	☐
2. Acute coronary syndromes including Myocardial infarction? If **YES**, please give date	D D M M Y Y	☐	☐
3. Coronary angioplasty (P.C.1) If **YES**, please give date of most recent intervention	D D M M Y Y	☐	☐
4. Coronary artery by-pass graft surgery? If **YES**, please give date	D D M M Y Y	☐	☐

Please proceed to Section 5B

5B Cardiac arrhythmia

Please tick ✓ the appropriate boxes	**YES**	**NO**
Is there a history of, or evidence of, cardiac arrhythmia? If **NO**, go to **Section 5C** **If YES** please answer all questions below and give details in **Section 7.**	☐	☐
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?	☐	☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	☐	☐

Full name of Applicant: …… **DOB:**……

3. Has an ICD or biventricular pacemaker (CRST-D type) been implanted ☐ ☐

4. Has a pacemaker been implanted? ☐ ☐
If **YES:-**
(a) Please supply date of implantation

DD	MM	YY

(b) Is the applicant free of symptoms that caused the device to be fitted? ☐ ☐

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

Please go to Section 5C

5C Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Please tick ✓ the appropriate boxes **YES** **NO**

Is there a history or evidence of **ANY** of the following: ☐ ☐
If **YES** please answer all questions below, and give details in **Section 7**.
If **NO**, go to **Section 5D**

1. Peripheral arterial disease (excluding Buerger's Disease) ☐ ☐

2. Does the patient have claudication? ☐ ☐

If **YES**, for how long in minutes can the patient walk at a brisk pace before being symptom-limited?
Please give details

3. Aortic aneursym (please circle) **YES** **NO**

If **YES:**
a) Site of Aneurysm: **Thoracic** ☐ **Abdominal** ☐

b) Has it been repaired successfully? ☐ ☐

c) Is the transverse diameter **currently** > 5.5cm? ☐ ☐

If **NO,** please provide latest measurement and date obtained

	DD	MM	YY

4. Dissection of the aorta repaired successfully: ☐ ☐
If **YES**, please provide copies of all reports to include those dealing with surgical treatment

5. Is there a history of Marfan's disease? ☐ ☐
If **YES**, provide relevant hospital notes

Please go to Section 5D

5D Valvular / congenital heart disease

Please tick ✓ the appropriate boxes **YES** **NO**

Is there a history of, or evidence of, valvular / congenital heart disease? ☐ ☐
If **NO**, go to **Section 5E**
If YES please answer all questions below and give details at **Section 7** of the form.

1. Is there a history of congenital heart disorder? ☐ ☐

Full name of Applicant: …… **DOB:**……

2. Is there a history of heart valve disease? ☐ ☐

3. Is there any history of embolism? (**not** pulmonary embolism) ☐ ☐

4. Does the applicant currently have significant symptoms? ☐ ☐

5. Has there been any progression since the last licence application? (if relevant) ☐ ☐

Please go to Section 5E

5E Cardiac Other

Please tick ✓ the appropriate boxes	**YES**	**NO**
Does the applicant have a history of **ANY** of the following conditions:	☐	☐

If **NO**, go to **Section 5F**
If YES please answer all questions below and give details at **Section 7** of the form.

(a) a history of, or evidence of heart failure?	☐	☐
(b) established cardiomyopathy?	☐	☐
(c) has a Left Ventricular Assist Device (LVAD) been implanted?	☐	☐
(d) a heart or heart/lung transplant?	☐	☐
(e) untreated atrial myxoma?	☐	☐

Please go to Section 5F

5F Cardiac Investigations

THIS SECTION MUST BE COMPLETED FOR ALL APPLICANTS

Please tick ✓ the appropriate boxes	**YES**	**NO**
1. Has a resting ECG been undertaken? 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 ECG report or comment at **Section 7***

2. Has an exercise ECG been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **Section 7** D D | M M | Y Y
Please provide relevant reports if available

3. Has an echocardiogram been undertaken (or planned)? ☐ ☐

a) If **YES** please give date and give details in Section 7 D D | M M | Y Y

(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)? ☐ ☐

If **YES**, please give date and give details in **Section 7** D D | M M | Y Y
Please provide relevant reports if available

Full name of Applicant: …… **DOB:**.....

5. Has a 24 hour ECG tape been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **Section 7** | D D | M M | Y Y |
Please provide relevant reports if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? ☐ ☐

If **YES**, please give date and give details in **Section 7** | D D | M M | Y Y |
Please provide relevant reports if available

Please go to Section 5G

5G Blood Pressure

THIS SECTION MUST BE COMPLETED FOR ALL APPLICANTS

Please tick ✓ the appropriate boxes **YES** **NO**

1. Please record today's blood pressure reading

2. Is the applicant on anti-hypertensive treatment? ☐ ☐

If **YES**, please provide three previous readings and dates.

	D D	M M	Y Y
	D D	M M	Y Y
	D D	M M	Y Y

6 General

Please tick ✓ the appropriate boxes **YES** **NO**

Please answer **ALL** questions in this section. If your answer is **'YES'** to any of the questions, please give full details in **Section 7**.

1. Is there **currently** any functional impairment that is likely to affect control of the vehicle? ☐ ☐

2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? ☐ ☐

3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? ☐ ☐

4. Is the applicant profoundly deaf? ☐ ☐
If **YES,**
is the patient able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone? ☐ ☐

5. Does the patient have a history of liver disease of any origin? ☐ ☐

If **YES**, please give details in **Section7**

6. Is there a history of renal failure? ☐ ☐

Full name of Applicant: …… **DOB:**……

If **YES**, please give details in **Section7**

7. (a) Is there a history of, or evidence of, obstructive sleep apnoea syndrome? ☐ ☐

(b) Is there any other **medical condition** causing excessive daytime sleepiness? ☐ ☐

If **YES,** please give diagnosis

If **YES** to 7a or b please give

(i) Date of diagnosis DD | MM | YY

(ii) Is it controlled successfully? ☐ ☐

(iii) If **YES**, please state treatment

(iv) Please state period of control

(v) Date last seen by consultant DD | MM | YY

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? ☐ ☐

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? ☐ ☐
If **YES,** please provide details of medication and symptoms in **Section 7**

10. Does the applicant have an ophthalmic condition? ☐ ☐
If **YES**, please provide details in **Section 7**

11. Does the applicant have a medical condition that would affect his/her ability to carry assistance dogs whilst driving? ☐ ☐

12. Does the applicant have a medical condition that would affect his/her ability to assist passengers in wheelchairs? ☐ ☐

13. Does the applicant have any other medical condition that could affect safe driving? ☐ ☐
If **YES,** please supply details

THIS SECTION IS INTENTIONALLY BLANK

7	**Please forward copies of relevant hospital notes only.** **PLEASE DO NOT send any notes not related to fitness to drive.**

Full name of Applicant: …… **DOB:**.....

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CIVIC CENTRE WEST PADDOCK LEYLAND PR25 1DH

Examining doctor's Details

To be completed by doctor carrying out the examination

Please ensure all sections of the form have been completed. Failure to do so will result in the form being rejected.

8 Doctor's details

I confirm that _____ is **FIT** ☐ **UNFIT** ☐

to undertake the duties of a Hackney Carriage / Private Hire Driver

Signature of Medical Practitioner _____ **Date** DD / MM / YYYY

Name
Address
Email address
Telephone
Fax number

(Please print name and address in capital letters)

Surgery Stamp

GMC Registration Number

9 Applicant's consent and declaration

Consent and Declaration
This section MUST be completed and must **NOT** be altered in any way. Please read the following important information carefully then sign the statements below.

Important information about Consent
On occasion, as part of the investigation into your fitness to drive, South Ribble Borough Council, 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 one or more of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

Consent and Declaration
I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State 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, and to inform my doctor(s) of the outcome of the case where appropriate.

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 driving licence and can lead to prosecution.

Signature _____ **Date** _____

Full name of Applicant: …… **DOB:**……

Applicant's Details

To be completed in the presence of the GP / Doctor carrying out the examination

Please make sure that you have printed your name and date of birth on each page before sending this form with your application

10 Your details

Your full name		Date of Birth	D D	M M	Y Y
Your address		Home tel. no.			
		Work/Day no.			
Email address					

About your GP / Group Practice

GP/Group name
Address
Telephone
Email address
Fax number

THIS SECTION IS INTENTIONALLY BLANK