NEWCASTLE CITY COUNCIL
Public Safety and Regulation

Civic Centre, Newcastle upon Tyne, NE1 8QH
Tel: (0191) 2783864; Email: licensingnewingtonroad@newcastle.gov.uk

MEDICAL CERTIFICATE ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

Applicant's details: (please complete)

Full name: ..... Date of Birth…….....

Current address:
.....
.....
……..

Applicant's consent and declaration:
(Please read the following carefully before signing and dating the declaration).

I authorise my General Practitioner(s) and Specialist(s) to release medical information about my condition, together with any relevant information relevant to fitness to drive, to the Licensing Section, Newcastle City Council for the purpose of the Council (by its Officers and/or Members) of assessing my fitness to drive a hackney carriage or private hire vehicle licensed by that Council.

I declare that to the best of my knowledge and belief all information given by me to my doctors in connection with the examination or the completion of the DVLA Group 2 medical examination report are true. In the event that the Council is not satisfied of my fitness to drive a hackney carriage or private hire vehicle, I confirm that I may, at my own cost, submit such further medical evidence to the Council as I consider appropriate.

Signed:.....Date:……

TO THE G.P. This form must be completed in full by the applicant's own G.P. or a medical practitioner who has reviewed the applicant's medical records. Please answer all questions and once completed sign the declaration at the end.

The Councils' policy on medical fitness requires that taxi drivers meet Group 2 Entitlement, as set out in the DVLA publication '*A Guide to the current Medical Standards of Fitness to Drive*'. This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to taxi drivers.

(a)	**Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner?** **If NO please provide details of patient's registered GP and surgery.** Doctor's Name: …… Address: ……... …… …… …… ……	**YES**	**NO**
(b)	**Have you reviewed the above applicant's medical records?**	**YES**	**NO**

1. VISION:

Please confirm the scale you are using to express the applicant's visual acuities

Snellen ☐ Snellen expressed as a decimal ☐ LogMar ☐

i	The visual acuity standard for Group 2 driving is **at least** 6/7.5 in the better eye and at least 6/60 in the other? (corrective lenses may be worn)	**Yes**	**No**
ii	Do corrective lenses have to be worn to achieve this standard? If **yes**, glasses ☐ contact lenses ☐ both together ☐	**Yes**	**No**
	If Glasses are worn for driving, is the corrective power greater than plus (+) 8 dioptres in any meridian of either lens?	**Yes**	**No**
	If correction is worn for driving, is it well tolerated? If NO please give full details in **Section 8.**	**Yes**	**No**
iii	Please provide visual acuities of each eye		

	Uncorrected		**Corrected (if applicable)**	
Right		Left	Right	Left

iv	Is there a defect in the patient's binocular field of vision (central and/or peripheral)?	**Yes**	**No**
v	Is there diplopia?	**Yes**	**No**
	(a) If yes, is it controlled	**Yes**	**No**
vi	Does the patient on questioning, report symptoms of intolerance to glare and /or impaired contrast sensitivity and/or impaired twilight vision.	**Yes**	**No**
vii	Does the patient have any other ophthalmic condition? If **YES** to questions **iv** – **vii**, please give details in **Section 8** and enclose any relevant visual field charts or hospital letters.	**Yes**	**No**

2. NERVOUS SYSTEM

i	Has the patient had any form of epileptic attack? If **YES** please answer questions a – f below.	**YES**	**NO**
	(a) Has the patient had more than one attack?	**Yes**	**No**

(b)	Please give date of first and last attack:	1st attack	.....	Last attack	.....

	(c) Is the patient currently on anti-epilepsy medication? If **YES** please give details of current medication: .... ……	**Yes**	**No**
	(d) If treated, please give date when treatment ended: ……		

	(e) Has the patient had a brain scan? If **YES** please state dates and supply reports if available. **MRI** ..... **CT**	**Yes**	**No**
	(f) Has the patient had an EEG? If **YES** please provide date and supply reports if available:	**Yes**	**No**
ii	Is there a history of blackout or impaired consciousness within the last 5 years? If **YES** please give dates and details at **Section 8**:	**Yes**	**No**
iii	Is there a history of, or evidence of, any of the conditions listed at **a – g** below? If **NO** go to Section **3**. If **YES** please answer the following questions, give dates and full details and supply any relevant reports.	**Yes**	**No**
	(a) Stroke / TIA (*please delete as appropriate*) If **YES** please give date: ..... Has there been a full recovery?	**Yes** **Yes**	**No** **No**
	(b) Sudden and disabling dizziness/vertigo within the last one year with a liability to recur	**Yes**	**No**
	(c) Subarachnoid haemorrhage	**Yes**	**No**
	(d) Serious head injury within the last 10 years	**Yes**	**No**
	(e) Brain tumour, either benign or malignant, primary or secondary	**Yes**	**No**
	(f) Other brain surgery/abnormality	**Yes**	**No**
	(g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis	**Yes**	**No**
3.	**DIABETES MELLITUS**		
i	Does the patient have diabetes mellitus? If **NO** please go to **Section 4**. If **YES** please answer the following questions.	**YES**	**NO**
ii	Is the diabetes managed by:-		
	(a) Insulin? If **YES** please give date started on insulin:	**Yes**	**No**
	(b) Exenatide/Byetta?	**Yes**	**No**
	(c) Oral hypoglycaemic agents and diet? If **YES** please provide details of medication:	**Yes**	**No**
	(d) Diet only?	**Yes**	**No**
iii	Does the patient test blood glucose at least twice every day?	**Yes**	**No**
iv	Is there evidence of:- (a) Loss of visual field?	**Yes**	**No**
	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?	**Yes**	**No**

	(c) Diminished / Absent awareness of hypoglycaemia?	**Yes**	**No**
v	Has there been any laser treatment for retinopathy? If **YES** please give date(s) of treatment	**Yes**	**No**
vi	Is there a history of hypoglycaemia during **waking** hours in the last 12 months requiring assistance? If **YES** to any of **iv – v** above please give details in **Section 8**.	**Yes**	**No**
4	**PSYCHIATRIC ILLNESS**		
	Is there a history of, or evidence of any of the conditions listed at 1 – 7 below? If **NO** please go to **Section 5**. If **YES** please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 8**. (Please enclose relevant notes). (If patient remains under specialist clinic(s) please give details in **Section 8**).	**YES**	**NO**
i	Significant psychiatric disorder within the past 6 months?	**Yes**	**No**
ii	A psychotic illness within the past 3 years, including psychotic depression?	**Yes**	**No**
iii	Dementia or cognitive impairment?	**Yes**	**No**
iv	Persistent alcohol misuse in the past 12 months?	**Yes**	**No**
v	Alcohol dependency in the past 3 years?	**Yes**	**No**
vi	Persistent drug misuse in the past 12 months?	**Yes**	**No**
vii	Drug dependency in the past 3 years?	**Yes**	**No**
5	**CARDIAC**		
	Is there a history of, or evidence of, Coronary Artery Disease? If **NO** please go to **Section 5B** If **YES** please answer all questions below and give details at **Section 8** of the form and enclose relevant hospital notes. **5A CORONARY ARTERY DISEASE**	**YES**	**NO**
i	Acute Coronary Syndromes including Myocardial Infarction? If **YES** please give date(s):	**Yes**	**No**
ii	Coronary artery by-pass graft surgery? If **YES** please give date(s):	**Yes**	**No**
iii	Coronary Angioplasty (P.C.I.)? If **YES** please give date of most recent intervention:	**Yes**	**No**
iv	Has the patient suffered from Angina? If **YES** please give the date of the last attack: ……	**Yes**	**No**

5 B	**CARDIA ARRHYTHMIA**		
	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 8** of the form	**YES**	**NO**
i	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 last 5 years?	**Yes**	**No**
ii	Has the arrhythmia been controlled satisfactorily for at least 3 months?	**Yes**	**No**
iii	Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	**Yes**	**No**
iv	Has a pacemaker been implanted? If **YES:** (a) Please supply date: ..... (b) Is the patient free of symptoms that caused the device to be fitted? (c) Does the patient attend a pacemaker clinic regularly?	**Yes** **Yes** **Yes**	**No** **No** **No**

5 C	**PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION**		
	Is there a history or evidence of ANY of the following: If **NO** go to **Section 5D.** If **YES** please answer the questions below and give details in **Section 8** of the form.	**YES**	**NO**
i	**Peripheral Arterial Disease (excluding Buerger's Disease)**	**Yes**	**No**
ii	Does the patient have claudication? If **YES** please give details as to how long in minutes the patient can walk at a brisk pace before being symptom limited	**Yes**	**No**
iii	**Aortic Aneurysm** If **YES:** (a) Site of Aneurysm (please tick): Thoracic ☐ Abdominal ☐ (b) Has it been repaired successfully? (c) Is the transverse diameter **currently** >5.5 cms? If **NO** please provide latest measurement: . Date obtained:	 **Yes** **Yes**	 **No** **No**
iv	**Dissection of the Aorta repaired successfully** If **YES** please provide copies of all reports to include those dealing with any surgical treatment.	**Yes**	**No**

5D	**VALVULAR/CONGENITAL HEART DISEASE**		
	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 in **Section 8** of the form	**YES**	**NO**
i	Is there a history of congenital heart disorder?	**Yes**	**No**
ii	Is there a history of heart valve disease?	**Yes**	**No**
iii	Is there any history of embolism? (**not** pulmonary embolism)	**Yes**	**No**
iv	Does the patient currently have significant symptoms?	**Yes**	**No**
v	Has there been any progression since the last licence application? (if relevant)	**Yes**	**No**
5E	**CARDIAC OTHER**		
	Does the patient 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 in **Section 8** of the form	**YES**	**NO**
	(a) A history of, or evidence of, heart failure?	**Yes**	**No**
	(b) Established cardiomyopathy?	**Yes**	**No**
	(c) A heart or heart/lung transplant?	**Yes**	**No**
5F	**CARDIAC INVESTIGATIONS** (This section must be filled in for all patients) (Please provide relevant reports)		
i	Has a resting ECG been undertaken? If **YES** does it show:	**YES**	**NO**
	(a) Pathological Q waves?	**Yes**	**No**
	(b) Left bundle branch block?	**Yes**	**No**
	(c) Right bundle branch block?	**Yes**	**No**
ii	Has the exercise ECG been undertaken (or planned)? If **YES** please provide date and give details in **Section 8**:	**Yes**	**No**
iii	Has an echocardiogram been undertaken (or planned)? (a) If **YES** please give date and give details in **Section 8**: ..... (b) If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%?	**Yes** **Yes**	**No** **No**
iv	Has a coronary angiogram been undertaken (or planned)? If **YES** please provide date and give details in **Section 8**:	**Yes**	**No**
v	Has a 24 hour ECG tape been undertaken (or planned)?	**Yes**	**No**

	If **YES** please provide date and give details in **Section 8**: ..		
vi	Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)? If **YES** please provide date and give details in **Section 8**:	**Yes**	**No**
5 G	**BLOOD PRESSURE (This section must be filled in for all patients)**		
I	Is today's best systolic pressure reading 180mm Hg or more? (Please give reading) **(BP reading: .....)**	**Yes**	**No**
ii	Is today's best diastolic pressure reading 100mm Hg or more? (Please give reading) **(BP reading: .....)**	**Yes**	**No**
iii	Is the patient on anti-hypertensive treatment? If **YES** to any of the above please provide three previous readings with dates if available: 1. B.P reading: …….. Date: ..... 2. B.P reading: …….. Date: ..... 3. B.P reading: …… Date:	**Yes**	**No**
6.	**GENERAL** (Please answer all questions in this section. If your answer is **YES** to any question please give full details in **Section 8**.		
i	Is there **currently** a disability of the spine or limbs likely to impair control of the vehicle?	**Yes**	**No**
ii	Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? If **YES** please give dates and diagnosis and state whether there is current evidence of dissemination?	**Yes**	**No**
iii	Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving?	**Yes**	**No**
iv	Is the patient 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?	**Yes** **Yes**	**No** **No**

v	Is there a history of either renal or hepatic failure?	**Yes**	**No**
vi	Is there a history of, or evidence of sleep apnoea syndrome? If **YES** please provide details: (a) Date of diagnosis: ..... (b) Is it controlled successfully? (c) If **YES** please state treatment: (d) Please state period of control: .... (e) Please provide neck circumference …….. (f) Please provide girth measurement in cm..... (g) Date last seen by consultant	**Yes** **Yes**	**No** **No**
vi	Does the patient suffer from narcolepsy/cataplexy?	**Yes**	**No**
vii	Is there any other **Medical Condition** causing daytime sleepiness? If **YES** please provide details: (a) Diagnosis: .... (b) Date of diagnosis: .... (c) Is it controlled successfully? (d) If **YES** please state treatment: (e) Please state period of control …… …… …… …… (f) Date last seen by consultant:	**Yes** **Yes**	**No** **No**
viii	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	**Yes**	**No**
ix	Does any medication currently taken cause the patient side effects that could affect safe driving? If **YES** please provide details:	**Yes**	**No**
x	Does the patient have any other medical condition that could affect safe driving? If **YES** please provide details:	**Yes**	**No**

7.	**ALCOHOL AND/OR DRUG MIS-USE** (Please answer all questions in this section. If your answer is **YES** to any question please give full details in **Section 8**.		
i	Does the patient show any evidence of being addicted to excessive use of alcohol?	**Yes**	**No**
ii	Does the patient show any evidence of being addicted to excessive use of drugs?	**Yes**	**No**

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

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GP'S DECLARATION:
Please read the following carefully before completing, signing and dating the declaration.
If the applicant/patient is not a registered patient with your practice or you have not reviewed his/her medical records then do not complete the declaration.

I certify that I am familiar with the current requirements of **Group 2 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 driver under the DVLA Group 2 medical standards

I certify that having regard to the foregoing, the applicant * MEETS / DOES NOT MEET
(*delete as appropriate) the minimum standards required for the DVLA Group 2 medical standards.

Doctor's name:		**Surgery Stamp:**
Surgery name:		
Surgery address:		
Signed:		**Date:**