MEDICAL IN CONFIDENCE -

IMPORTANT: All medicals completed for ERYC Hackney Carriage or Private Hire Vehicle Driver's Licences MUST be completed by the applicants Registered General Practitioner or a partner in the same practice who has access to your full historic and current medical history.

For the Applicant:

This Certificate is the method by which the East Riding of Yorkshire Licensing Authority is advised that the Applicant is considered medically fit to drive hackney carriage/private hire vehicles.

Applicants must be examined and certified as being medically fit (to a Group 2 Standard) by their registered GP or another GP in the same practice with which they are registered, who must have taken into account previous medical history. The Council may require a further examination or referral following this initial certification.

This certificate is not one which must be issued free of charge as part of the National Health Service. The Council accepts no liability to pay for it.

For the Applicants Doctor:

This certificate is for the confidential use of the East Riding of Yorkshire Council,

East Riding of Yorkshire Council has adopted the Group 2 Medical Standards for Fitness to Drive Hackney Carriage and Private Hire Vehicles in accordance with the DVLA and Department for Transport Best Practice Guidance.

Group 2 Medical reports are only accepted from the applicant's own registered doctor, or another doctor in the same practice, taking into account an applicant's full medical records.

In completing this certificate, GPs are asked to have regard to the DVLA "Assessing fitness to driver a guide for medical professionals"? (Current edition).

When making an application: This medical form will only be valid for 6 weeks following the date of the medical assessment being carried out.

Medicals must be completed every 5 years until the age 65. From age 65 medical examinations must be completed annually**.**

***Unless the GP specifies a more regular interval, your medical will automatically expire as above.**

What do you have to do?

1. **If you have any medical conditions this should be declared at your first stage appointment. Please contact the Taxi Hub prior to your appointment should you have failed to declare any conditions.**

2. Fill in **Section 11 and Section 12** of this report in the presence of the Doctor carrying out the examination.

3. This medical report must be sent to the East Riding of Yorkshire Council's Licensing Team by your GP if you are an existing licensed driver with East Riding of Yorkshire Council or given to you (as the applicant) to submit with your complete application as a new applicant.

What the doctor has to do?

1. **Please arrange for the patient to be seen and examined.**

2. You may find it helpful to consult DVLA's "Assessing fitness to driver a guide for medical professionals"? which the East Riding of Yorkshire Council has formally adopted. Further help can be obtained by telephoning 0300 790 6806 and asking to speak to one of the DVLA Medical Advisers. They would need to know the applicant's full name, address and date of birth. They would also need to know in addition your name, the surgery address and phone number and a time when it might be convenient to return your call.

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 any type of driving licence, they must inform Drivers Medical Group, D7, DVLA, Swansea SA99 1TU – immediately.

4. Please ensure that you have completed all the sections.

5. Once completed please either return to the following address for existing licensed drivers;

   Licensing Team, County Hall, Cross Street, Beverley, HU17 9BA.

   Or if the patient is a new applicant for a Hackney Carriage/Private Hire driver's licence, please give the completed form to the applicant.

If this report does not bring out important clinical details with respect to driving, please give details in Section 7.

GP Signature **Date**

Medical Examination

Please answer all questions

Please give patient's weight ☐ **kg/st and height** ☐ **ft/cms**

Please give details of smoking habits, if any ☐

Please give number of alcohol units taken each week ☐

1 Vision

Date when first licensed to drive a Hackney Carriage or Private Hire Vehicle. ☐

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

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. Please state the visual acuity of each eye.

Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard are not met, the applicant may need further assessment by an optician.

Uncorrected		**Corrected** (Using the prescription worn for driving)	
R	L	R	L

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

4. 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 ☐

5. Were corrective lenses worn to meet this standard? ☐ ☐
   If **yes**, glasses ☐ contact lenses ☐ both together ☐

6. If glasses (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? ☐ ☐

7. If correction is worn for driving, is it well tolerated? ☐ ☐

GP Signature ☐ **Date** ☐

If you answer Yes to ANY of the following (6 to 9), give details in the box provided over leaf.

	YES	NO
8. Is there a history of medical condition that may affect the applicants binocular field of vision (central and/or peripheral)?	☐	☐
If formal visual field testing is considered necessary, ERYC will commission this at a later date.		
9. Is there diplopia?	☐	☐
(a) Is it controlled? If **Yes**, please ensure you give full details in the box provided.	☐	☐
10. Does the applicant on questioning, report symptoms of intolerance to glare and/ or impaired contrast sensitivity and/ or impaired twiilight vision?	☐	☐
11. Does the applicant have any other ophthalmic condition?	☐	☐

If yes to any of the questions relating to visual health, please give full details below.

Details

Date of examination D D M M Y Y

Name (print)

Signature

Date of signature D D M M Y Y

Please provided your GOC, HPC or GMC number

Doctor/Optometrist/Optician's Stamp

GP Signature **Date**

2 Nervous System

Please tick the appropriate box(es)

	YES	NO
Is there a history of, or evidence of any neurological disorder? **If NO, go to section 2** **If YES, please answer all the questions below, give full details Including any relevant hospital notes.**	☐	☐

1. Has the applicant had any form of seizure? ☐ ☐
If **NO**, please go to **question 3**
If **YES**, please answer questions a-f

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

(b) Please give date of first and last attack

First attack D D M M Y Y

Last attack D D M M Y Y

(c) Is the applicant currently on anti-epileptic medication?
If **YES**, please fill in current medication in **section 9**

(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 give details in section 6

(f) Has the applicant had an EEG? ☐ ☐
If **YES** to any of above, please supply reports if available.

	YES	NO
2. Stroke or TIA? ☐☐ ☐☐ ☐☐	☐	☐
3. **If yes, please give date**		
a. Has there been a **FULL** recovery?	☐	☐
b. Has a carotid ultra sound been undertaken?	☐	☐
c. If **yes**, was the carotid artery stenosis>50% in either carotid artery?	☐	☐
d. Has there been a carotid endarterectomy?	☐	☐
4. Sudden and disabling dizziness/ vertigo within the last year with a liability to recur?	☐	☐
5. Subarachnoid Hemorrhage?	☐	☐
6. Serious traumatic brain injury within the last 10 years?	☐	☐

GP Signature ☐ **Date** ☐

7. Any form of brain tumor? ☐ YES ☐ NO

8. Other brain surgery or abnormality? ☐ ☐

9. Chronic neurological disorders? ☐ ☐

10. Parkinson's disease? ☐ ☐

11. Is there a history of blackout or impaired consciousness within the last 5 years? ☐ ☐

12. Does the applicant suffer from narcolepsy? ☐ ☐

3 Diabetes Mellitus

Please tick the appropriate box(es)	**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 D D M M Y Y		
(b) If treated with insulin, are there at least 3 months of blood glucose reading 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 fill in current medication in **section 9**	☐	☐
(f) Diet only?	☐	☐
3. (a) Does the applicant test blood glucose at least twice every day?	☐	☐
(b) Does the applicant test at times relevant to driving?	☐	☐
(c) Does the applicant keep 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?	☐	☐

GP Signature ☐ **Date** ☐

	YES	NO
6. Is there evidence of:- (a) Loss of visual field?	☐	☐
(b) Sever 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

Is there a history of, or evidence of, **ANY** of the conditions listed at 1-7 below?

- Please enclose relevant hospital notes
- If applicant remains under specialist clinic(s), ensure details are filled in at section 7.

	YES	NO
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 month	☐	☐
5. Alcohol dependence in the past 3 years	☐	☐
6. Persistent drug misuse in the past 12 months	☐	☐
7. Drug dependence in the past 3 years	☐	☐

If yes to ANY of questions 4-7, please state how long this has been controlled

Please give details of past consumption or name drug(s) and frequency

GP Signature **Date**

5 Cardiac

5A Cardiac

Is there a history of, or evidence of, coronary artery disease? **YES** ☐ **NO** ☐

If **NO**, go to **section 5B**
If **YES**, please answer all questions below and give details at section 7 of the form and enclose relevant hospital notes.

1. Has the applicant suffered from Angina? ☐ ☐
   If **YES**, please give the date of last know 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

If yes to any of the above questions, are there any health problems (e.g. physical/ mobility, arthritis or (OPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?

Yes ☐ **No** ☐ **If yes, please list below:**

5B Cardiac Arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? **YES** ☐ **NO** ☐

If **NO**, go to **section 5C**
If **YES**, please answer all question below and give details in **section 7**

1. Has there been **significant** disturbance of cardiac rhythm? ☐ ☐
   i.e Sinoatrial disease, significant artrio-ventricar conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 5 years

GP Signature **Date**

2. Has the arrhythmia been controlled satisfactory for at least 3 months? ☐ ☐

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? D D M M Y Y

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

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

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

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	YES	NO
Is there a history or evidence of **ANY** of the following:	☐	☐

If **NO**, go to **section 5D**.
If **YES**, please answer all questions below and give details in **section 7**

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

2. Does the applicant have claudication? ☐ ☐
If **YES**, how long in minute can the applicant walk at a brisk pace before being symptom-limited?

Please give details

3. Aortic aneurysm ☐ ☐
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

D D M M Y Y

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

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

GP Signature **Date**

5D Valvular/Congenital Heart Disease

	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 in **section 7** of the form.

1.	Is there a history of congenital heart disorder?	☐	☐
2.	Is there a history of heart valve disease?	☐	☐
3.	Is there a history of aortic stenosis?	☐	☐
4.	Is there any history of embolism? (**not** pulmonary embolism)	☐	☐
5.	Does the applicant currently have significant symptoms?	☐	☐
6.	Has there been any progression since the last licence application? (if relevant)	☐	☐

5E Cardiac Other

	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 and give details in **section 7**

1.

(a)	A history of, or evidence of, heart failure?	☐	☐
(b)	Establishment cardiomyopathy?	☐	☐
(c)	Has a left Ventricular Assist Device (LVAD) been implanted?	☐	☐
(d)	A heart or heart/lung transplant?	☐	☐
(e)	Untreated atrial myxoma	☐	☐

2. *Cardiac Channelopathies: Is there a history of, or evidence of the following conditions?*

	a. Brugada Syndrome? *b. Long QT Syndrome?*	☐	☐

If yes, please list which/ or both syndromes below:

GP Signature **Date**

5F Cardiac Investigation

This section must be filled in for all applicants

	YES	NO
1. Has a resting ECG been undertaken? If **YES**, does it show:-	☐	☐
(a) Pathological Q waves?	☐	☐
(b) Left bungle 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**.

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

If **YES**, please give date and give details in **section 6**

D D M M Y Y

Please provided relevant report 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 provided relevant report if available

	YES	NO
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

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

GP Signature ☐ **Date** ☐

5G Blood Pressure

1. Please record today's blood pressure reading

2. Is the applicant on anti-hypertensive treatment?

   If **YES** provide three previous reading with dates if available

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

If blood pressure is 180mm/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.

Please record today's best resting blood pressure reading.

3.

	YES	NO
4. Is there a history of malignant hypertension?		

6 General

Please answer **ALL** questions. I '**YES**' to any give full details in **section 7**

	YES	NO
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 applicant able to communicate in the event of an emergency to speech or by using a device e.g. a textphone?		
5. Does the applicant have a history of liver disease of any origin?		

GP Signature **Date**

If **YES**, please give details in **section 7**

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

If **YES**, please give details in **section 7**

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 details diagnosis

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

(a) Date of diagnosis D D M M Y Y

(ii) Is it controlled successfully? ☐ ☐

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

(iv) Please state period of control

(v) Date last seen by consultant

D D M M Y Y

	YES	NO
8. Does the applicant have sever 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 any other medical condition that could provide details in **section 7**	☐	☐
If **YES**, please provide details in **section 7**		

GP Signature **Date**

7 Further Details

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

8 Mobility

An important part of the role of a licensed taxi/private hire driver involves assisting passengers this includes the lifting and carrying of luggage, support to those with disabilities and provide assistance to passengers in the event of an emergency. Drivers are therefore required to access and egress the vehicle without difficulty and have adequate mobility to fulfil these functions.

Does the applicant have adequate mobility in order to assist and support passengers?

Yes ☐ **No** ☐

If no, please provide details below of the medical condition that would prohibit the applicant from assist and support passengers.

GP Signature **Date**

9 Consultants details

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

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

Consultant in
Name
Address

Date of last appointment D D M M Y Y

10 Medication

Please provide details of all current medication (continue on a separate sheet if necessary) any detail of prescribed and its possible impact on driving ability.

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

GP Signature **Date**

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

Medication	Dosage
Reason for taking:	
Possible impact on driving ability:	

GP Signature **Date**

11 Applicant's consent and declaration

Consent and Declaration

This section must be completed and must not be altered in any way.

Please sign the statements below.

I authorise my registered Doctor(s) and Specialist(s) to release reports to the East Riding of Yorkshire Council's Licensing Team about my medical condition.

I authorise the Secretary of State and his representatives to divulge relevant medical information about me to Doctors or Paramedical staff (including the East Riding of Yorkshire Council's Licensing Team's Doctor) as necessary in the course of medical enquiry into my fitness to drive.

I declare that I have checked the details I have given on the enclosed questionnaire and that to the best of my knowledge they are correct.

Signature **Date**

I authorise the East Riding of Yorkshire Council's Licensing Team to release medical information to my Doctors and or Specialists about the outcome of my case. (This is to enable your Doctor to advise you about the fitness to drive)

Signature **Date**

Note about consent *You will see that we have asked for your consent, not only for the release of medical reports from your doctors, but also that we might in our turn very occasionally release medical information to Doctors or Paramedical staff, either because we wish you to be examined, and the doctors need to know the medical details, or because we require further information. You need to understand quite clearly how we define Paramedical staff. Many patients need to be assessed in Driving Assessment Centres who employ Occupational Therapists, Physiotherapists, Orthoptists and experienced driving instructors, all of who need to understand about a patient's medical condition in order to produce a helpful report. Only occasionally do we need to do this and it may well not apply in your case. We never under any circumstances release information which is not relevant to fitness to drive, nor would we expect to receive this from your Doctors.*

We hope you will find this helpful and reassuring and will return the signed consent so that we might proceed with our investigations.

Applicant Name **DOB**

GP Signature **Date**

Applicant's Details

To be completed in the presence of the Registered GP 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.

12 Your Details

Your Name		*Date of Birth*	
Your Address		*Telephone – Home*	
		Daytime/work	

About your GP/Group Practice

About your Consultant/Specialist current or previous (if applicable)

GP/Group Name		*Consultants Name*	
Address		*Address*	
Telephone		*Telephone*	

Date Last Seen

GP Signature **Date**

13. Medical Practitioner Details and Declaration

To be completed by the Registered GP carrying out the examination.

Name of Applicant	
Date of Birth	
Address	
Does the applicant in your opinion meet the standard of medical fitness required for a DVLA group two standard driver as set out in the current edition of the DVLA "Assessing fitness to driver a guide for medical professionals"?	Yes/No Comments:
Is there any abnormality present that is not included in the above questions?	
Do you consider future examination necessary? Is so, in what period of time?	

I certify that I am the registered GP of the applicant named below and that I have full access to their historic medical records to complete this form.

I certify that I have this day examined the applicant, who has signed this form in my presence.

I understand that the individual is a licensed taxi/private hire driver (or applying to become a driver) is a professional driving occupation subject to stringent checks for reasons of safeguarding (transporting passengers including children on a 1:1 basis).

The applicants/driver's medical circumstances and medical history pose no risk in their view to the travelling public (including transportation of children and those adults who may be at risk of harm).

GP Signature	
GP Full Name	
GMC Reference Number	
Date	

GP Signature **Date**

IMPORTANT: in line with the Council's policy All medicals for ERYC Hackney Carriage or Private Hire Vehicle Driver's Licences MUST be completed by the applicants own Registered General Practitioner or partner at the GP's Practice.

ONCE COMPLETED, THE GP SHOULD FORWARD THIS MEDICAL REPORT MARKED 'PRIVATE & CONFIDENTIAL' TO:

East Riding of Yorkshire Council
Licensing Team
County Hall
Cross Street
Beverley
HU17 9BA

or email to taxi.hub@eastriding.gov.uk

GP Signature **Date**