



## Private Hire and Hackney Carriage Group I Medical Form

FULL NAME OF APPLICANT: .....

DATE OF BIRTH: .....

ADDRESS: .....

This certificate, which must be completed by a Registered Medical Practitioner, is NOT one which must be issued free of charge as part of the National Health Service. East Staffordshire Borough Council accepts no liability to pay for it.

**In completing this Certificate, Medical Practitioners are asked to have regard to the recommendations by the Medical Commission for Accident Prevention in their booklet “Medical Aspects of Fitness to Drive” and/or to the notes for the Guidance of Doctors conducting these examinations prepared by the British Medical Association.**

**PLEASE NOTE: MEDICALS WILL NOT BE ACCEPTED BY THE LICENSING OFFICE IF THEY ARE MORE THAN 3 MONTHS OLD.**

I CERTIFY THAT I HAVE TODAY EXAMINED ....., THE APPLICANT, WHO HAS SIGNED THIS FORM IN MY PRESENCE, AND DECLARE THAT IN MY OPINION, AND IN THE LIGHT OF THE APPLICANT'S FULL MEDICAL HISTORY, **HE/SHE IS FIT/UNFIT\*** TO DRIVE A HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE.

*\*delete as necessary*

IF A FURTHER EXAMINATION IS NECESSARY, PLEASE STATE IN WHAT PERIOD OF TIME.....

**I confirm that the applicant is registered as a patient with this surgery**

Signature of Medical Practitioner: .....

Date: .....

Telephone Number: .....

Signature of Applicant:  
.....

**MEDICAL CERTIFICATE - to be completed by the Doctor**  
**Please answer all questions**

**SECTION 1 VISION** (Please see *Eyesight Notes 3i and 3ii* on page 2)

**YES**      **NO**

(a) Is the visual acuity as measured by the Snellen Chart **AT LEAST 6/9** in the better eye and **AT LEAST 6/12** in the other? (Corrective lenses may be worn)

(b) If corrective lenses have to be worn to achieve this standard:

(i) is the **UNCORRECTED** acuity **AT LEAST 3/60** in the **RIGHT EYE**?

(ii) is the **UNCORRECTED** acuity **AT LEAST 3/60** in the **LEFT EYE**?

(c) Please state all the visual acuities for all applicants:

**UNCORRECTED**

**CORRECTED** (if applicable)

Right  Left

Right  Left

(d) If there is **NO** perception of light in one eye, on what date did the applicant become monocular or lose the sight in one eye?

(e) Is there a full binocular field of vision? (central and/or peripheral)

(f) Is there uncontrolled diplopia?

**SECTION 2 NERVOUS SYSTEM**

(a) Has the applicant had major or minor epileptic seizure(s)?

(i) Please give date of last seizure

(ii) Please give date when treatment ceased

(b) Is there a history of blackout or impaired consciousness within the past 5 years?

(c) Is there a history of stroke or TIA within the past 5 years?

(d) Is there a history of sudden disabling dizziness/vertigo within the last 1 year?

(e) Is there a history of chronic and/or progressive neurological disorder?  
 If **YES** please give details in **SECTION 7**.

(f) Is there a history of brain surgery?  
 If **YES** please give date and details in **SECTION 7**.

(g) Is there a history of serious head injury?

If **YES** please give details in **SECTION 7**.

(h) Is there a history of brain tumour, either benign or malignant, primary or secondary?  
If **YES** please give details in **SECTION 7**.

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### SECTION 3 DIABETES MELLITUS

**YES NO**

(a) Does the applicant have diabetes mellitus?  
If **YES** please answer the following questions.  
If **NO** proceed to **SECTION 4**.

(b) Is the diabetes managed by:

(i) Insulin?

(ii) Oral hypoglycaemic agents and diet?

(iii) Diet only?

(c) Is the diabetes control generally satisfactory?

(d) Is there evidence of:

(i) Loss of visual field?

(ii) Has there been bilateral laser treatment?  
If **YES** please give date

(iii) Severe peripheral neuropathy?

(iv) Significant impairment of limb function or joint position sense?

(v) Significant episodes of hypoglycaemia?

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### SECTION 4 PSYCHIATRIC ILLNESS

(a) has the applicant suffered from or required treatment for a psychosis in the past 3 years?  
If **YES** please give details in **SECTION 7**.

(b) has the applicant required treatment for any other psychiatric disorder within the past 6 months? If **YES** please give details in **SECTION 7**.

(c) Is there confirmed evidence of dementia?

(d) (i) Is there a history of alcohol misuse or alcohol dependency in the past 3 years?

(ii) Is there a history of illicit drug/substance use or dependency in the past 3 years? If **YES** please give details in **SECTION 7**.

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## SECTION 5 GENERAL

- (a) Has the applicant currently a significant disability of the spine or limbs which is likely to impair control of the vehicle?    
If **YES** please give details in **SECTION 7**.
- (b) Is there a history of bronchogenic or other malignant tumour with a significant liability to metastasise cerebrally? If **YES** please give dates and diagnosis and state whether there is current evidence of dissemination.    
.....
- (c) Is the applicant profoundly deaf?
- (d) Could this be overcome by any means to allow a telephone to be used in an emergency?

## SECTION 6 CARDIAC

### (a) Coronary Heart Disease

Is there a history of:

- (i) Myocardial Infarction?  
If **YES** please give date.

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

- (ii) Coronary artery by-pass graft?  
If **YES** please give date.

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

- (iii) Coronary Angioplasty?  
If **YES** please give date

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

- (iv) Any other Coronary artery procedure?  
If **YES** please give details in **SECTION 7**.

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

- (v) Has the applicant suffered from angina?

<input type="checkbox"/>	<input type="checkbox"/>
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- (vi) Is the applicant **STILL** suffering from angina or only remains angina free by the use of medication?

<input type="checkbox"/>	<input type="checkbox"/>
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- (vii) Has the applicant suffered from Heart Failure?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

- (viii) Is the applicant **STILL** suffering from Heart Failure?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

- (ix) Has a resting ECG been undertaken?  
If **YES** please give date.

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

- (x) Does it show pathological Q waves?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

- |  |                          |                          |
|--|--------------------------|--------------------------|
| (xi) Does it show Left Bundle branch block?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| (xii) Has an exercise ECG been undertaken (or planned)?              | <input type="checkbox"/> | <input type="checkbox"/> |
| (xiii) Has an angiogram been undertaken?<br>If YES please give date. | <input type="checkbox"/> | <input type="checkbox"/> |
|  | <input type="text"/>     |                          |

**YES      NO**

**(b) Cardiac Arrhythmia**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| (i) Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years? If <b>YES</b> please give details in <b>SECTION 7</b> .                       | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Has the arrhythmia (or medication) caused symptoms of sudden dizziness or impairment of consciousness or any symptom likely to distract attention driving within the past 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Has Echocardiography been undertaken? If <b>YES</b> please give details in <b>SECTION 7</b> .   | <input type="checkbox"/> | <input type="checkbox"/> |
| (iv) Has any exercise test been undertaken? If <b>YES</b> please give details in <b>SECTION 7</b> .   | <input type="checkbox"/> | <input type="checkbox"/> |
| (v) Has a PACEMAKER been implanted?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (vi) If <b>YES</b> was it implanted to prevent Bradycardia?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (vii) Is the applicant now free of sudden and/or disabling symptoms?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (viii) Does the applicant attend a pacemaker clinic regularly?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (ix) Has a Cardiac defibrillator been implanted or antivenricular tachycardia been fitted?  | <input type="checkbox"/> | <input type="checkbox"/> |

**(c) Other Vascular Disorders**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| (i) Is there a history of Aortic aneurysm with a transverse diameter of 5 cm or more? (Thoracic or abdominal) | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) If YES has the aneurism been successfully repaired?  | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Is there symptomatic peripheral arterial disease?   | <input type="checkbox"/> | <input type="checkbox"/> |

**(d) Blood Pressure**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| (i) Is there a history of hypertension with BP readings consistently greater than 180 systolic or 100 diastolic? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If **YES** please supply most recent reading with dates.

.....  
(ii) If treated, does the medication cause any side effects likely to affect safe driving?

**(e) Valvular Heart Disease**

(i) Is there a history of valvular heart disease (with or without surgery)?

(ii) Is there any history of embolism?

(iii) Is there any history of arrhythmia – intermittent or persistent?

(iv) Is there persistent dilation or hypertrophy of either ventricle?  
If **YES** please give details in **SECTION 7**.

**(f) Cardiomyopathy**

(i) Is there established cardiomyopathy? If **YES** please give details in **SECTION 7**.

(ii) Has there been a heart or heart/lung transplant? If **YES** please give details in **SECTION 7**.

**(g) Congenital Heart Disorders**

(i) Is there a congenital heart disorder?

(ii) If **YES** is it currently regarded as minor?

(iii) Is the patient in the care of a Specialist clinic?  
If **YES** please give details in **SECTION 7**.

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**SECTION 7** *You may wish to forward copies of hospital notes separately if you need to provide extra information.*

**MEDICAL PRACTITIONER DETAILS**

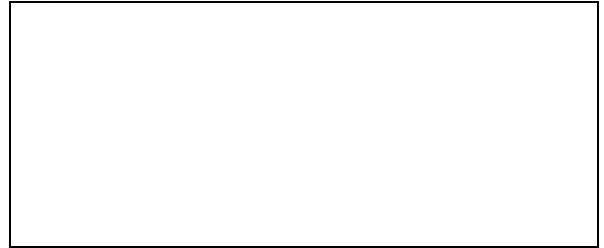
To be completed by the Medical Practitioner carrying out the examination

**SECTION 8**

Surgery Stamp

Name:

Address:



Signature of Medical Practitioner:

Date:

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**APPLICANT'S DETAILS**

To be completed in the presence of the Medical Practitioner carrying out the examination

**SECTION 9**

Your Name:

Date of Birth:

Address:

Post Code:

Telephone Number:

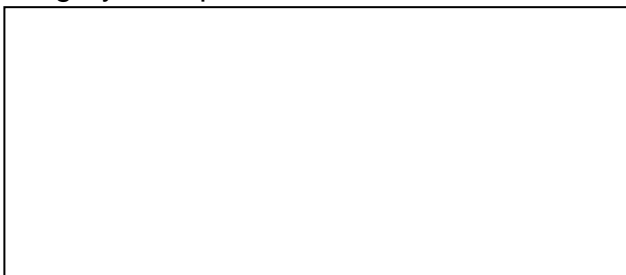
**ABOUT YOUR GP/GROUP PRACTICE** *(if applicable)*

GP/Group Name:

Address:

Telephone Number:

Surgery Stamp



## Appendix C

### Group I Medical Examinations



## **GROUP I MEDICAL EXAMINATIONS FOR AN APPLICANT FOR A LICENCE TO DRIVE HACKNEY CARRIAGES /PRIVATE HIRE VEHICLES**

**(SECTION 57, (2) LOCAL GOVERNMENT (MISCELLANEOUS PROVISIONS) ACT, 1976**

### **For the Applicant:**

All medicals for applications for a Hackney Carriage or Private Hire driver's licences must be carried out by your own GP. Further medicals will be required every three years unless specified by the GP. Medicals will not be accepted if they are over 3 months old.

### **For the Applicant's GP:**

This certificate is for the confidential use of the Council. Any fee charged is payable by the applicant.

### **Medical Policy**

- The Council adopted the Group I Medical standards for fitness to drive Hackney Carriage & Private Hire Vehicles in accordance with the DVLA and Department for Transport best practice guidance.
- Group I Medical reports are only accepted from the applicant's own GP, or another doctor in the same practice.
- Any significant change in medical conditions that could affect driving must be reported immediately to DVLA and the Licensing Authority.

Contact us; Licensing Office, Town Hall, King Edward Place, Burton upon Trent, Staffordshire, DE14 2EB