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**. ☐ ☐

YES **NO**

SECTION 3 DIABETES MELLITUS

(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? ☐ ☐

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.** ☐ ☐

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. ☐

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

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

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

(v) Has the applicant suffered from angina? ☐ ☐

(vi) Is the applicant **STILL** suffering from angina or only remains angina free by the use of medication? ☐ ☐

(vii) Has the applicant suffered from Heart Failure? ☐ ☐

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

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

(x) Does it show pathological Q waves? ☐ ☐

(xi) Does it show Left Bundle branch block? ☐ YES ☐ NO

(xii) Has an exercise ECG been undertaken (or planned)? ☐ YES ☐ NO

(xiii) Has an angiogram been undertaken? ☐ YES ☐ NO
If YES please give date. ☐

(b) **Cardiac Arrhythmia**

(i) Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years? If **YES** please give details in **SECTION 7.** ☐ YES ☐ NO

(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? ☐ YES ☐ NO

(iii) Has Echocardiography been undertaken? If **YES** please give details in **SECTION 7**. ☐ YES ☐ NO

(iv) Has any exercise test been undertaken? If **YES** please give details in **SECTION 7.** ☐ YES ☐ NO

(v) Has a PACEMAKER been implanted? ☐ YES ☐ NO

(vi) If **YES** was it implanted to prevent Bradycardia? ☐ YES ☐ NO

(vii) Is the applicant now free of sudden and/or disabling symptoms? ☐ YES ☐ NO

(viii) Does the applicant attend a pacemaker clinic regularly? ☐ YES ☐ NO

(ix) Has a Cardiac defibrillator been implanted or antiventricular tachycardia been fitted? ☐ YES ☐ NO

(c) **Other Vascular Disorders**

(i) Is there a history of Aortic aneurysm with a transverse diameter of 5 cm or more? (Thoracic or abdominal) ☐ YES ☐ NO

(ii) If YES has the aneurism been successfully repaired? ☐ YES ☐ NO

(iii) Is there symptomatic peripheral arterial disease? ☐ YES ☐ NO

(d) **Blood Pressure**

(i) Is there a history of hypertension with BP readings consistently greater than 180 systolic or 100 diastolic? ☐ YES ☐ NO

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 or 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**. ☐ ☐

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:

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