CHESHIRE EAST COUNCIL
DRIVER MEDICAL

BLOCK LETTERS PLEASE:

FULL NAME OF APPLICANT: …….. DATE OF BIRTH……..……..

ADDRESS: ……..……..……..……

……..……..……..…. POST CODE ……..……

This certificate, which must be completed by a Registered Medical Practitioner within the practice with which the Applicant is registered, is NOT one which must be issued free of charge as part of the National Health Service. Cheshire East Council accepts no liability to pay for it. Unless any other arrangements have been made for the payment of the fee, the applicant is to pay.

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. Cheshire East Council make no discrimination between Group 2 and Taxi Licences.

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: ……

MEDICAL PRACTITIONER DETAILS
To be completed by the Medical Practitioner carrying out the examination

Surgery Stamp

Name ……

Address ……

……..

SIGNATURE OF MEDICAL PRACTITIONER: ……..……

TELEPHONE NO: …..……..…..…… DATE ……..……..

SIGNATURE OF APPLICANT: ……..……..

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

SECTION 1 VISION **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**. ☐ ☐

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? If **YES refer to SECTION 8.**	☐	☐
(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**.	☐	☐

	YES	NO
(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?	☐	☐
(e) Is the applicant taking any medication that would impair his/her level of attention whilst driving?	☐	☐

……

……

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?	☐ ☐
(xii)	Has an exercise ECG been undertaken (or planned)?	☐ ☐
(xiii)	Has an angiogram been undertaken? If YES please give date.	☐ ☐ ☐

		YES	NO
(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.**	☐	☐
(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?	☐	☐
(iii)	Has Echocardiography been undertaken? If **YES** please give details in **SECTION 7**.	☐	☐
(iv)	Has any exercise test been undertaken? If **YES** please give details in **SECTION 7.**	☐	☐
(v)	Has a PACEMAKER been implanted?	☐	☐
(vi)	If **YES** was it implanted to prevent Bradycardia?	☐	☐
(vii)	Is the applicant now free of sudden and/or disabling symptoms?	☐	☐
(viii)	Does the applicant attend a pacemaker clinic regularly?	☐	☐
(ix)	Has a Cardiac defibrillator been implanted or antiventricular tachycardia been fitted?	☐	☐
(c) **Other Vascular Disorders**			
(i)	Is there a history of Aortic aneurysm with a transverse diameter of 5 cm or more? (Thoracic or abdominal)	☐	☐
(ii)	If YES has the aneurism been successfully repaired?	☐	☐
(iii)	Is there symptomatic peripheral arterial disease?	☐	☐
(d) **Blood Pressure**			
(i)	Is there a history of hypertension with BP readings consistently greater than 180 systolic or 100 diastolic? 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?	☐	☐

	YES	NO
(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.

SECTION 8

The Council recognises that the Group 2 standards preclude the licensing of drivers with insulin treated diabetes. However, exceptional arrangements do exist for drivers with insulin treated diabetes, who can meet a series of medical criteria, to obtain a licence to drive category C1 vehicles (i.e. 3500-7500 kgs lorries). The Council has determined to apply the C1 standards to taxi and PHV drivers with insulin treated diabetes.

The additional medical criteria which are required to be met in relation by applicants with insulin treated diabetes are as follows[1]:

Qualifying Conditions for applicants

• They must have had no hypoglycemic attacks requiring assistance whilst driving within the previous 12 months.
• They will not be able to apply for category C1 or C1E entitlement until their condition has been stable for a period of at least one month.
• They must regularly monitor their condition by checking their blood glucose levels at least twice daily and at times relevant to driving. (The use of a memory chip meters for such monitoring is advised).
• They must arrange to be examined every 12 months by a hospital consultant, who specialises in diabetes. At the examination the consultant will require sight of their blood glucose records for the last 3 months.
• They must have no other condition, which would render them a danger when driving C1 vehicles.
• They will be required to sign an undertaking to comply with the directions of doctors(s) treating the diabetes and to report immediately to DVLA any significant change in their condition.

DECLARATION **to be completed by applicants with insulin treated diabetes**

I undertake that I will arrange to be examined every 12 months by a hospital consultant who specialises in diabetes.

I undertake to comply with the directions of doctor(s) treating the diabetes and to report immediately to the DVLA and the Council any significant change in my conditions.

SIGNATURE:…… Date: ……

[1] Taken from "At a glance Guide to the current Medical Standards of Fitness to Drive" DVLA (February 2007)

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 No (home): ……..…… …… (work): ……..……...……

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

GP/GROUP NAME: ……

ADDRESS: ……..

…….. TELEPHONE NO: ……...……

ABOUT YOUR CONSULTANT/SPECIALIST *(if applicable)*

CONSULTANT NAME: ……..……..

ADDRESS: ……

……..…… Post Code: ……..…… Telephone No: ….…….

DECLARATION AND AUTHORISATION **to be completed by applicant**.

(If you have knowingly given false information in this examination you are liable to prosecution)

Consent and Declaration
This section MUST be completed and must NOT be altered in any way. Please sign the statement below.

I declare that I have checked the details I have given and to the best of my knowledge they are correct. I authorise the release of any relevant medical reports to the examining doctor, if required, for the purpose of obtaining a licence to drive Hackney Carriages or Private Hire Vehicles.

SIGNATURE:…… Date: ……