MEDICAL EXAMINATION REPORT

Information and useful notes

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Important Information

You must get the medical report filled in if:

- This is your first application
- If you are renewing your licence and you are age 45 or over. From the age of 45 a medical report will be required every 5 years until you are 65. From age 65 onwards driving licences are issued for one year only.

Instructions for you and your doctor are detailed on the next 2 pages.

A. What you have to do

1. You must arrange an appointment for a full medical examination with a doctor registered or practising in the United Kingdom or in any other EC/EEA country but who is currently employed or practising at your own registered medical practice.

   You must read section C pages 4-8 before arranging an appointment to find out if you can meet Group 2 medical standard.

2. If, after reading the notes, you have any doubts about your fitness to meet the medical standards ask a doctor/optician for advice before getting them to fill in the form. If you do not do this we may not issue you with a licence. The doctor will normally charge you for filling in the form and those registered for VAT charge VAT on top of their fee. The report must be completed at your expense.

3. Fill in section 9 and section 10 of the medical report when you are with the doctor carrying out the medical examination.

4. If you develop a condition which could affect safe driving (see pages 4-8) and you hold, or are applying for a licence you must inform the licensing authority immediately.

5. You must check all sections of the medical report have been filled in fully before submitting your medical/application. Incomplete medicals will be returned which will delay your application.

6. You may be required to undergo a further medical examination at your expense to prove your fitness to drive. Please note that in the case of new applications they will not be granted until your fitness to drive has been ascertained. In the case of renewals, or during the currency of a licence should a medical condition develop, your licence may be suspended, or not renewed pending the outcome of a further examination and/or test.

7. If you have any queries please call 0117 357 4900 between 9am and 5pm Monday to Friday to speak to a member of the Licensing Team.

B. Information for the doctor

1. The patient must be registered at the practice where you work. You must have access to and have had regard to the patients medical record when completing the report.

2. Please fully examine the patient and include urine screening for glucose.

3. Fill in sections 1-7 and 8 of the medical report. You may find it helpful to read DVLA's "At a Glance" booklet. You can download this from the "medical rules for all drivers" section of www.direct.gov.uk/driverhealth.

4. Make sure you fill in all sections, including consultant/specialist details on the front of the form and the surgery/practice stamp or GMC registration number in section 8.

C. Medical Standards

Medical standards for Private Hire and Hackney Carriage drivers are higher than those for regular car drivers. All applicants must meet the DVLA Group 2 Entitlement of fitness to drive.

If you have any of the following medical conditions you will not be able to obtain, or retain a Private Hire or Hackney Carriage driver licence.

1. Epilepsy or liability to epileptic attacks

If you have been diagnosed as epileptic or have had a spontaneous epileptic attack(s) which includes all events major, minor and auras, you will need to be free of further epileptic attack without taking anti-epilepsy medication for 10 years. If you have a condition that causes an increased liability to epileptic attacks for example serious head injury, the risk of you having a seizure must fall to no greater than 2% per annum. If these conditions are not met then your application will be refused or your licence revoked.

1a. First epileptic attack or solitary seizure

If you have had only one epileptic attack or a solitary seizure, you may be entitled to drive after 5 years from the date of the seizure provided that you are able to satisfy the following criteria:

- No relevant structural abnormality has been found in the brain on scanning.
- No definite epileptic activity has been found on EEG (record of the brain waves).
- You have achieved at least five years without anti-epilepsy drugs since the seizure.
- You have the support of your neurologist.
- Your risk of a further seizure is considered to be 2% or less per annum (each year).

You are strongly advised to discuss your eligibility to meet the Group 2 Standard of fitness to drive with your doctor(s) before applying for a licence.

2. Diabetes

From 15 November 2011 new Group 2 Standards were introduced for persons with insulin treated diabetes. Any applicant with insulin treated diabetes will not be able to obtain a licence unless they can satisfy the following criteria:

- No episode of hypoglycaemia requiring the assistance of another person has occurred in the preceding 12 months.
- Has full awareness of hypoglycaemia.
- Regularly monitors blood glucose at least twice daily and at times relevant to driving using a glucose meter with a memory function to measure and record blood

glucose levels. At the annual examination by an independent Consultant Diabetologist, 3 months of blood glucose readings must be available.

- Must demonstrate an understanding of the risks of hypoglycaemia.

There are no other debarring complications of diabetes such as a visual field defect.

3. Eyesight

All new applicants must have:

- A visual acuity of at least 6/7.5 (0.8 decimal) in the better eye;
- A visual acuity of at least 6/60 (0.1 decimal) in the other eye; and
- Where glasses are worn to meet the minimum standards, they should have a corrective power ≤ +8 dioptres in any meridian of either lens.

Normal binocular field

All applicants must have a normal binocular field of vision. This means that any area of defect in a single eye is totally compensated for by the field of the other eye.

Various grandfather rights may apply to existing licence holders. Please contact the Licensing Team on 0117 357 4900 between 9am and 5pm Monday to Friday to speak to a member of the Licensing Team for further information.

4. Other medical conditions

Any person who cannot meet the recommended medical guidelines for the following conditions is likely to have their application refused or licence revoked:

- If there is established coronary heart disease an exercise tolerance test or other stress test will be required at intervals not to exceed 3 years. After Acute Coronary Syndrome an LV ejection fraction of greater than 40% is required.
- Within 3 months of a coronary artery bypass graft (CABG).
- Acute coronary syndrome, Angina, heart failure or cardiac arrhythmia which remain uncontrolled.
- Implanted cardiac defibrillator.
- Hypertension where the blood pressure is persistently 180 systolic or more and/or 100 diastolic or more.
- A stroke or Transient Ischaemic Attack (TIA) within the last 12 months.
- Unexplained loss of consciousness with liability to recurrence.
- Meniere's Disease, or any other sudden and disabling vertigo within the past 1 year, with a liability to recurrence.
- Difficulty in communicating by telephone in an emergency.
- Major brain surgery and/or recent severe head injury with serious continuing after effects.
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders with

symptoms likely to affect safe driving.

- Psychotic illness, in the past 3 years.
- Serious psychiatric illness.
- If major psychotropic or neuroleptic medication is being taken.
- Alcohol and/or drug misuse in the past 1 year or alcohol and/or drug dependency in the past 3 years.
- Dementia.
- Any malignant condition in the last 2 years, with a significant liability to metastasise (spread) to the brain.
- Any other serious medical condition likely to affect the safe driving of a medium/large goods or passenger carrying vehicle.

5. Facts you should know about excessive sleepiness/tiredness and driving

There is no excuse for falling asleep at the wheel and it is not an excuse in law.

- Up to one fifth of accidents on motorways and other monotonous types of roads may be caused by drivers falling asleep at the wheel.
- 18-30 year old males are more likely to fall asleep at the wheel when driving late at night.
- Modern life styles such as early morning starts, shift work, late and night socialising, often lead to excessive tiredness by preventing adequate rest.
- All drivers who fall asleep at the wheel have a degree of warning.
- Natural sleepiness/tiredness occurs after eating a large meal.
- Changes in body rhythm produce a natural increased tendency to sleep at two parts of the day:

  Midnight - 6am
  2pm - 4pm
- Although no one should drink and drive at any time, alcohol consumed in the afternoon may be twice as potent in terms of producing sleepiness and driving impairment as the same amount taken in the evening.
- Prescribed or over-the-counter medication can cause sleepiness as a side effect. Always check the label, if you intend to drive.

Medical conditions causing sleepiness

All drivers are subject to the pressures of modern life, but many drivers are unaware that some medical conditions also cause excessive sleepiness/tiredness. These, alone or in combination with the factors mentioned previously, may be sufficient to make driving unsafe. A road traffic accident may be the first clear indication of such a sleep disorder.

Obstructive Sleep Apnoea (OSA)

- OSA is the most common sleep related medical disorder.

- OSA significantly increases the risk of traffic accidents.
- OSA occurs most commonly, but not exclusively, in overweight individuals.
- Partners often complain about snoring and notice that the sufferers have breathing pauses during sleep.
- OSA suffers rarely wake from sleep feeling fully refreshed and tend to fall asleep easily when relaxing.
- At least four in every hundred men have OSA.
- Sleep problems arise more commonly in older people.
- Lifestyle changes for example weight loss or cutting back on alcohol, will help ease the symptoms of OSA.
- The most widely effective treatment for OSA is Continuous Positive Airway Pressure (CPAP). This requires the patient to wear a soft face mask during sleep to regulate breathing. This treatment enables patients to have a good nights sleep, so reducing daytime sleepiness and improving concentration.

Other sleep related conditions

Illnesses of the nervous system, such as **Parkinson's Disease, Multiple Sclerosis** (MS)**, Motor Neurone Disease** (MND) and **Narcolepsy** may also cause excessive sleepiness although sometimes these illnesses alone may cause drivers to be unfit for driving.

Tiredness or excessive sleepiness can be a non-specific symptom of Parkinson's Disease, MS, MND or may also be related to prescribed medication.

Narcolepsy also causes daytime sleepiness/tiredness as well as other symptoms that may be disabling for drivers.

Medical Examination Report

To be filled in by the Doctor. The Patient must fill in sections 9 and 10 in the doctor's presence (please use black ink)

Before filling in this form, please read the attached 'Medical Examination Report - Information and useful notes' booklet Section B (page 5)

Patients weight (kg) ______ Height (cms) ______

Details of smoking habits, if any ______

Number of alcohol units taken each week ______

Is the urine analysis positive for Glucose? Yes ☐ No ☐ (please tick ✓ appropriate box)

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

1	2	3

Date of last appointment

D D / M M / Y Y	D D / M M / Y Y	D D / M M / Y Y

Medication	Dosage	Reason Taken

1 Vision

(please see Eyesight notes on page 7 of the attached 'Medical Examination Report - Information and useful notes' booklet

Please tick ✓ the appropriate box(es) — **YES** / **NO**

1. Is the visual acuity **at least** 6/7.5 in the better eye and at least 6/60 in the other? (corrective lenses may be worn) as measured with the full size 6m Snellen chart ☐ ☐

2. Do corrective lenses have to be worn to achieve this standard? ☐ ☐
   If **YES**, is the:-
   (c) correction well tolerated? ☐ ☐

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart.
   Please convert any 3 metre readings to the 6 metre equivalent.

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

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

5. Is there a defect in the patient's binocular field of vision (central and/or peripheral)? ☐ ☐

6. Is there diplopia? (controlled or uncontrolled)? ☐ ☐

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central or peripheral)? ☐ ☐

Patient's Name: ______ **Date of Birth:** ______

		YES	NO
8.	Does the patient have any other ophthalmic condition?	☐	☐
9.	Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision?	☐	☐

If **YES** to any of questions 4 to 9 please give details in **Section 7** and enclose any relevant visual field charts or hospital letters.

2 Nervous System

		YES	NO
1.	Has the patient had any form of epileptic attack? If **YES**, please answer questions a - f	☐	☐
(a)	Has the patient had more than one attack?	☐	☐
(b)	Please give date of first and last attack First attack DD MM YY Last attack DD MM YY		
(c)	Is the patient currently on anti-epilepsy medication? If **YES**, please fill in current medication on the appropriate section on the front of this form	☐	☐
(d)	If treated, please give date when treatment ended DD MM YY		
(e)	Has the patient had a brain scan? If **YES**, please state: MRI ☐ Date DD MM YY CT ☐ Date DD MM YY *Please supply reports if available*	☐	☐
(f)	Has the patient had an EEG? If **YES**, please provide dates DD MM YY *Please supply reports if available*	☐	☐
2.	Is there a history of blackout or impaired consciousness within the last 5 years? If **YES**, please give date(s) and details in **Section 7**	☐	☐
3.	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 tick the relevant box(es) and give dates and full details at **Section 7** and supply and relevant reports.	☐	☐
(a)	Stroke/TIA *please delete as appropriate* If **YES**, please provide dates DD MM YY	☐	☐
	Has there been a **full** recovery	☐	☐
(b)	Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur	☐	☐
(c)	Subarachnoid haemorrhage	☐	☐
(d)	Serious head injury within the last 10 years	☐	☐
(e)	Brain tumour, either benign or malignant, primary or secondary	☐	☐
(f)	Other brain surgery/abnormality	☐	☐
(g)	Chronic neurological disorders e.g. Parkinson’s disease, Multiple Sclerosis	☐	☐

3 Diabetes Mellitus

		YES	NO
1.	Does the patient 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 DD MM YY	☐	☐
(b)	If treated with insulin are there at least 3 months of blood glucose readings stored on a memory meter?	☐	☐
(c)	Other injectable treatments?	☐	☐
(d)	A sulphonylurea or a Glinide?	☐	☐
(c)	Oral hypoglycaemic agents and diet? If **YES**, please fill in current medication on the appropriate section on the front of this form	☐	☐
(d)	Diet only?	☐	☐
3. (a)	Does the patient test blood glucose at least twice every day?	☐	☐
(b)	Does the patient test at times relevant to driving?	☐	☐
(c)	Does the patient carry fast acting carbohydrate in the vehicle when driving?	☐	☐
(d)	Does the patient have a clear understanding of diabetes and the necessary precautions for		

safe driving? ☐ ☐

4. Is there evidence of:
   (a) Loss of visual field? ☐ ☐
   (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? ☐ ☐
5. Is there any evidence of impaired awareness of hypoglycaemia? ☐ ☐

6. Has there been laser treatment for retinopathy? ☐ ☐
   Or intra-vitreal treatment for retinopathy?
   If **YES**, please give date(s) of treatment

7. Is there a history of hypoglycaemia in the last 12 months requiring assistance of another person? ☐ ☐

If **YES** to any of 4 - 7 above, please give details in **Section 7**

4 Psychiatric Illness

	YES	NO
Is there a history of, or evidence of, any of the conditions listed in 1-7 below?	☐	☐

If **NO**, please go to **Section 5**
If **YES** please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7.**

NB Please enclose relevant hospital notes
NB If patient remains under specialist clinic(s) ensure details are filled in at the top of page 1

		YES
1.	Significant psychiatric disorder within the past 6 months	☐
2.	A psychotic illness within the past 3 years, including psychotic depression	☐
3.	Dementia or cognitive impairment	☐
4.	Persistent alcohol misuse in the past 12 months	☐
5.	Alcohol dependency in the past 3 years	☐
6.	Persistent drug misuse in the past 12 months	☐
7.	Drug dependency in the past 3 years	☐

5 Cardiac

	YES	NO
Is there a history of, or evidence of, Coronary Artery Disease?	☐	☐

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

5A Coronary Artery Disease

		YES	NO
1.	Acute Coronary Syndromes including Myocardial Infarction? If **YES**, please give date(s) DD MM YY	☐	☐
2.	Coronary artery by-pass graft surgery? If **YES**, please give date(s) DD MM YY	☐	☐
3.	Coronary Angioplasty (P.C.I)? If **YES**, please give date of most recent intervention DD MM YY	☐	☐

Patient's Name: **Date of Birth:**

		YES	NO
4.	Has the patient suffered from Angina? If **YES**, please give date of the last known attack DD MM YY	☐	☐

Please go to next Section 5B

5B Cardiac Arrhythmia

		YES	NO
	Is there a history of, or evidence of, cardiac arrhythmia? If **NO**, please go to **Section 5C** If **YES** please answer all questions below and give details in **Section 7** of the form.	☐	☐
1.	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 the last 5 years	☐	☐
2.	Has the arrhythmia been controlled satisfactorily 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 provide date DD MM YY		
	(b) Is the patient free of symptoms that caused the device to be fitted?	☐	☐
	(c) Does the patient attend a pacemaker clinic regularly?	☐	☐

Please go to Section 5C

5C Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection

		YES	NO
	Is there a history of, or evidence of, ANY of the following? If **NO**, please go to **Section 5D** If **YES** please **tick** ✓ALL relevant boxes below, and give details in **Section 7** of the form.	☐	☐
1.	**PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)**	☐	☐
2.	Does the patient have claudication? If **YES** for how long in minutes can the patient 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** >5.5cms? If **NO**, please provide latest measurement and date obtained ☐ DD MM YY	☐	☐
4.	**DISSECTION OF THE AORTA REPAIRED SUCCESSFULLY:** If **YES** please provide copies of all reports to include those dealing with any surgical treatment.	☐	☐

Please go to Section 5D

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?	☐	☐

Patient's Name: ☐ **Date of Birth:** ☐

		YES	NO
3.	Is there any history of embolism? (**not** pulmonary embolism)	☐	☐
4.	Does the patient currently have significant symptoms?	☐	☐
5.	Has there been any progression since the last licence application? (if relevant)	☐	☐

Please go to Section 5E

5E Cardiac Other

	YES	NO
Does the patient have a history of **ANY** of the following	☐	☐

(a) a history of, or evidence of heart failure?
(b) established cardiomyopathy?
(c) a heart or heart/lung transplant?
(d) Untreated atrial myxoma

If YES please give full details in Section 7 of the form. If NO, go to Section 5F.

5F Cardiac Investigations

This section must be filled in for all patients

		YES	NO
1.	Has a resting ECG been undertaken?	☐	☐
	If **YES**, does it show:		
	(a) pathological Q waves?	☐	☐
	(b) left bundle branch block?	☐	☐
	(c) right bundle branch block?	☐	☐
2.	Has an exercise ECG been undertaken (or planned)? If **YES**, please give date DD MM YY and give details in **Section 7** *Please provide relevant reports if available*	☐	☐
3.	Has an echocardiogram been undertaken (or planned)? (a) If **YES**, please give date DD MM YY and give details in **Section 7** (b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%? *Please provide relevant reports if available*	☐	☐
4.	Has a coronary angiogram been undertaken (or planned)? If **YES**, please give date DD MM YY and give details in **Section 7** *Please provide relevant reports if available*	☐	☐
5.	Has a 24 hour ECG tape been undertaken (or planned)? If **YES**, please give date DD MM YY and give details in **Section 7** *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 DD MM YY and give details in **Section 7** *Please provide relevant reports if available*	☐	☐

Please go to Section 5G

5G Blood Pressure

This section must be filled in for all patients

		YES	NO
1.	Is today's best systolic pressure reading 180mm Hg or more?	☐	☐
2.	Is today's best diastolic pressure reading 100mm Hg or more? Please give today's reading ☐	☐	☐
3.	Is the patient on anti-hypertensive treatment?	☐	☐

If YES, to any of the above, please provide three previous readings with dates, if available

6 General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in **Section 7.**

		YES	NO
1.	Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle?	☐	☐
2.	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		
	(a) Is there any evidence the patient has a cancer that causes fatique or cachexia that affects safe driving?	☐	☐
3.	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?	☐	☐
4.	Does the patient have a history of alcoholic liver disease and/or liver cirrhosis of any origin? If **YES**, please give details in **Section 7**	☐	☐
5.	Is there a history of, or evidence of, sleep apnoea syndrome?	☐	☐
	If **YES**, please provide details		
	(a) Date of diagnosis D D M M Y Y		
	(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 cms		
	(g) Date last seen by consultant		
6.	Does the patient suffer from narcolepsy/cataplexy? If **YES**, please give details in **Section 7**	☐	☐
7.	Is there any other **Medical Condition**, causing excessive daytime sleepiness?	☐	☐
	If **YES**, please provide details		
	(a) Diagnosis		
	(b) Date of Diagnosis D D M M Y Y		
	(c) Is it controlled successfully?	☐	☐
	(d) If **YES**, please state treatment		
	(e) Please state period of control		
	(f) Date last seen by consultant		
8.	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
9.	Does any medication currently taken cause the patient side effects that could affect safe driving?	☐	☐
	If **YES**, please provide details of medication and symptoms		

Patient's Name: ______ **Date of Birth:** ______

10. Does the patient have any other medical condition that could affect safe driving? ☐ ☐
If **YES**, please provide details

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

Medical Practitioner Details

To be filled in by Doctor carrying out the examination

8 Doctor and Practice Details

Name	
Address	
Email address	
Fax number	

Surgery Stamp

Declaration:

PLEASE ENSURE THIS SECTION IS COMPLETED

1. I CERTIFY that having had regard to the DVLA's "At a glance Guide to the current Medical Standards of Fitness to Drive" I have examined the applicant and confirm he/she in my opinion:

Meets the Group 2 entitlement of fitness to drive*

Does not meet the Group 2 entitlement of fitness to drive*

(*PLEASE DELETE AS NECESSARY).

	YES	NO
If the applicant is under 45 years of age do you consider a further examination necessary before the applicant reaches 45 years of age; or	☐	☐
If the applicant is over 45 do you consider a further medical examination necessary before 5 years time?	☐	☐

If YES to either statement in what period of time do you consider a further examination necessary

2. I have checked the applicant's photo identification and confirm that the applicants name is the same as that on his/her identification and his/her appearance is the same as that on his/her photograph. As such I assume he/she is the person on the photograph

3. I confirm the patient is registered at the medical practice detailed above and that I have had access to their medical records when completing this medical.

Signature of Medical Practitioner:

Date of Examination:

Patient's Name: **Date of Birth:**

Patient's Details

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

9 Your Details

Your full name
Your address
Email address

Date of Birth D D M M Y Y

Home phone number

Work/Daytime number

10 Patient's consent and declaration

You must sign this declaration when you are with the doctor who is completing this report.

I authorise my Doctor(s) and Specialist(s) to release report/medical information about my condition, relevant to my fitness to drive, to Bristol City Council in conjunction with my application and during the period that a licence (if granted) is in force.

I authorise Bristol City Council to disclose such relevant information as may be necessary to the investigation of my fitness to drive in conjunction with my application and during the period that a licence (if granted) is in force to doctors, paramedical staff, and to inform my doctor(s) of the outcome of the case where appropriate.

I understand that Bristol City Council may require me to undergo further medical tests at my expense now or at any point in the future, if a licence is granted, in order to establish my fitness to drive.

I declare that I have checked the details I have given on the report and that, to the best of my knowledge and belief, they are correct.

Signature of Applicant:

Date:

Patient's Name: **Date of Birth:**