

Medical examination report

for a Group 2 (Hackney carriage/private hire driver licence)

For advice on how to fill in this form, read the leaflet INF4D available at www.gov.uk/reapply-driving-licence-medical-condition

Please use black ink when you fill in this report.

DR.....

Medical professionals must fill in this sections

Important information for doctors carrying

before completing the report.

out examinations.

Applicants:

you must fill in the section below and include your full name and date of birth at the end of each page. You must also complete the declaration on page 8.

	Before you fill in this report, you must check the
	applicant's identity and decide if you are able to fill in the Vision on assessment on page 2. If you are unable to do
Important: This report is only valid for 3 months from	this, you must inform the applicant that they will need to
date of examination.	ask an optician or optometrist to fill in the Vision
Name:	assessment.
	Examining medical professional
Address:	
	Has a company employed you or booked you to
	carry out this examination?
	Yes I No I
	If Yes, you must give the company's details below.
Postcode:	If INTEL years mount aire years and the enderson details
	If 'No', you must give your practice address details
	below. (Refer to section C of INF4D.) Company or practice address
Contact number:	
Email address:	
Your doctor's details (only fill in if different from	
	Postcode:
examining doctor's details)	
GP's name:	Company or practice contact number
	GMC number
Practice address:	
	I can confirm that I have checked the applicant's
	documents to prove their identity. Signature of examining doctor
	Applicant's weight (kg) Applicant's height (cm)
Contact number:	
	Number of units of Alcohol consumed each week
Email address:	
	Does the applicant smoke?
	Do you have access to the
	applicant's full medical record?

Important: Signatures must be provided at the end of this report

Li	Medical examination river & Vehicle censing gency To be filled in by an optici	ment D4
1. 2.	 Please confirm (✓) the scale you are using to express the applicant's visual acuities. Snellen Snellen expressed as a decimal LogMAR The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other. (a) Please provide uncorrected visual acuities for each eye. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment 	 6. Does the applicant report symptoms of any of the following that impairs their ability to drive? Please indicate below and give full details in Q8 below. (a) Intolerance to glare (causing incapacity rather than discomfort) and/or (b) Impaired contrast sensitivity and/or (c) Impaired twilight vision
	by an optician. R L Yes No (b) Are corrective lenses worn for driving? If no, go to Q3. If yes, please provide the visual acuities using	 7. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? If yes, please give full details in Q8 below.
	 If yes, please provide the visual addites daing the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician. R L (c) What kind of corrective lenses are worn to meet this standard? Glasses Contact lenses Both together (d) If glasses are worn for driving, is the corrective power greater than plus (+)8 Yes No dioptres in any meridian of either lens? No is it well tolerated? Yes No If no, please give full details in Q8. 	8. Details or additional information
3.	Is there a known visual field defect?	I confirm that this report was filled in by me at examination and the applicant's history has been
4.	Are there any medical conditions which might result in a visual field defect? (a) If yes, has a visual field defect Yes No been excluded? (b) Please provide the condition: If formal visual field testing is considered necessary, DVLA will commission this at a later date.	taken into consideration. Signature of examining doctor, optician or optometrist Date of signature Please provide your GOC or GMC number Doctor, optometrist or optician's stamp
5.	Is there diplopia? Yes No (a) Is it controlled? Yes No Please indicate below and give full details in Q8. Patch or Glasses Other glasses with with/without (if other please frosted glass prism provide details)	
Ар	plicant's full name Please do not de	Date of birth D D M M M M

Driver & Vehicle Licensing Agency

Medical examination report Medical assessment

D4

Must be filled in by a doctor

1	Neurological disorders			2	Diabetes m	ellitus			
Doe of ar ques If no	se tick ✓ the appropriate boxes s the applicant have a history or evidence ny neurological disorder (see conditions in stions 1 to 11 below)? 9, go to section 2, Diabetes mellitus s, please answer all questions below.	Yes	No	lf n e	es the applicant h o, go to section es, please answer Is the diabetes (a) Insulin?	3, Cardiac r all questions be treated by:		Yes Yes	No No
1.	 Has the applicant had any form of seizure? (a) Has the applicant had more than one seizure episode? (b) Please give date of first and last episode First episode Last episode (c) Is the applicant currently on anti-seizure medication? (d) If no longer treated, when did treatment end? (e) Has the applicant had a brain scan? If yes, please give details in section 9, page 6. 		No	2.	 of blood glu a memory m If no, please (c) Other injecta (d) A Sulphonyl (e) Oral hypogly (f) Diet only? (a) Does the ap at least twice 	ve date in. least 6 continuo cose readings st neter or meters? give details in s able treatments? urea or a Glinide vcaemic agents a	cored on ection 9, page ? and diet? d glucose		
2.	 Has the applicant experienced any dissociative/functional seizures? (a) If yes, please give date of most recent episode. (b) If yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving? 	Yes	No		to driving (n the start of t 2 hours whil (c) Does the ap carbohydrat whilst driving (d) Does the ap understandi	o more than 2 ho he first journey a st driving)? plicant keep fas e within easy rea	ours before and every t-acting ach lear nd the		
3.	Stroke or TIA? If yes, give date.			3.	(a) Has the app	licant ever had emic episode? awareness of		Yes	No
	(d) Is there a history of multiple strokes/TIAs?			4.	Is there a histor in the last 12 m assistance of ar	onths requiring t	mia he	Yes	No
4.	Sudden and disabling dizziness or vertigo within the last year with a liability to recur?					ve details and d	ates below.		
5.	Subarachnoid haemorrhage (non-traumatic)?								
6.	Significant head injury within the last 10 years?								
7.	Any form of brain tumour?								
8.	Other intracranial pathology?								
9.	Chronic neurological disorder(s)?					MM			
10.	Parkinson's disease?			5.		laser treatment tment for retinop		Yes	No
11.	Blackout, impaired consciousness or loss of awareness within the last 5 years?				If yes, please gi recent date of t	ve most			
Арј	plicant's full name					Date of birth	DDM	A N	M

3 Cardiac	c Peripheral arterial disease (excluding Buerger's disease)
a Coronary artery disease	aortic aneurysm/dissection
Is there a history or evidence of Yes No coronary artery disease?	Is there a history or evidence of peripheral Yes No arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? If no, go to section 3d, Valvular/congenital heart disease If yes, please answer all questions below.
1. Has the applicant ever had an episode of angina? Yes No If yes, please give the date of the last known attack. If yes have been been been been been been been be	1. Peripheral arterial disease? (excluding Buerger's disease) Yes No Ves No Image: State of the state
2. Acute coronary syndrome including Yes No myocardial infarction?	2. Does the applicant have claudication?
If yes, please give date.	3. Aortic aneurysm? Yes No If yes: (a) Site of aneurysm: Thoracic Abdominal (b) Has it been repaired successfully?
4. Coronary artery bypass graft surgery? Yes No	 (c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes. cm
5. If yes to any of the above, are there any Yes No physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details below.	 4. (a) Dissection of aorta? (b) If yes, has the dissection been successfully repaired? If yes to 4a, please provide copies of all reports including those dealing with any surgical treatment.
b Cardiac arrhythmia Is there a history or evidence of Yes No cardiac arrhythmia? If no, go to section 3c, Peripheral arterial disease If yes, please answer all questions below.	 5. Is there a history of Marfan's disease? (a) If yes, are there any associated risk factors*? *risk factors include – family history of aortic dissection greater than 3mm per year increase than aneurysm diameter pregnancy
1. Has there been a significant disturbance Yes No of cardiac rhythm causing/likely to cause	d Valvular/congenital heart disease
incapacity in the last 5 years? Image: Constraint of the last 5 years? 2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes No	valvular or congenital heart disease?
3. Has an ICD (Implanted Cardiac Defibrillator) Yes No or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator	1. Is there a history of congenital heart disease? Yes No
 (CRT-D type) been implanted? 4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? 	2. Is there a history of heart valve disease? Yes No (a) If yes, are they symptomatic? Image: Comparison of the symptomatic of
If yes: (a) Please give date of implantation.	3. Is there a history of aortic stenosis? Yes No If yes, please provide relevant reports (including echocardiogram). Image: Comparison of the stenosis of the st
 (b) Is the applicant free of the symptoms that caused the device to be fitted? (c) Does the applicant attend a pacemaker clinic regularly? 	4. Has there been any progression (either Yes No clinically or on scans etc) since the last licence application?
Applicant's full name	Date of birth

e Cardiac other

Applicant's full name

Is there a history or evidence of heart failure? Yes No if no, go to section 3f, Cardiac channelopathies if yes, please answer all questions below. 1. Please provide the NYHA class, if known. 2. Established cardiomyopathy? Yes No other cardiac assist device (LVAD) or other cardiac assist device been implanted? 4. A heart or heart/lung transplant? Yes No other cardiac channelopathies 1. Evidence or history of pulmonary arterial hypertension? 1. Cardiac channelopathies 1. Brugada syndrome? Yes No 2. Long QT syndrome? Yes No 1. Brugada syndrome? Yes No 2. Long QT syndrome? Yes No 1. Brugada syndrome? Yes No 2. Long QT syndrome? Yes No 1. Please record to fails in section 9, page 6. 3. Blood pressure 3. Please for the section setting blood pressure reading. 4. Please record to all short be answered. 5. Protect in the provided. 5. Protect in the provided setting blood pressure reading. 5. Protect in the provided setting blood pressure reading. 5. Protect in the provided setting blood pressure reading. 5. Protect in the provide three previous readings with dates if available. 5. If yes, please provide three previous readings 5. With dates if available. 5. Is the applicant on anti-hypertensive treatment? Yes No 5. If yes, please provide three previous readings 5. With dates if available. 5. Is the applicant on anti-hypertensive treatment? 5. Is the applicant on anti-hypertensive treatment? 5. Is there a history of the following: 5. Is there a history of the following: 5. Is the applicant on block (RBBB)? 5. Is there a history of the following: 5. Is the applicant on setting block (RBBB)? 5. Is the a				
2. Established cardiomyopathy? Yes 1f yes, please give details in section 9, page 6. 3. Has a left ventricular assist device (LVAD) or ves Yes No other cardiac assist device been implanted? Yes No attent or heart/lung transplant? Yes No fload asyndrome? Yes No flyes to either, please give details in section 9, page 6. Blood pressure Sl Blood pressure is 180 mm/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. 1. Please record today's best resting blood pressure reading. / / / No </td <td>If no, go to section 3f, Cardiac channelopathies</td> <td></td> <td>No</td> <td></td>	If no, go to section 3f, Cardiac channelopathies		No	
If yes, please give details in section 9, page 6. 3. Has a left ventricular assist device (LVAD) or ves No other cardiac assist device been implanted? 4. A heart or heart/lung transplant? Yes 5. Evidence or history of pulmonary arterial hypertension? 6. Evidence or history of pulmonary arterial hypertension? 7. Cardiac channelopathies Is there a history or evidence of the following conditions? If no, go to section 3g, Blood pressure 1. Brugada syndrome? Yes No if yes to either, please give details in section 9, page 6. 7. Blood pressure 7. All questions must be answered. If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm/Hg diastolic or more, please take a further 2 readings in the box provided. 1. Please record today's best resting blood pressure reading. 1. Please record today's best resting blood pressure readings if yes, please provide three previous readings with dates if available. 1. / 1. Do 1. Do 1. 1. S the applicant on anti-hypertensive treatment? Yes No if yes, please answer questions 1 to 5. 1. Is there a history of the following: Yes No 1. Is there a history of the following: Yes No (a) left bundle branch block (IBBB)? (b) o	1. Please provide the NYHA class, if known.			
c. inter cardiac assist device been implanted? implanted? interview in		Yes	No	
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2. Long QT syndrome?	4. A heart or heart/lung transplant?	Yes	No	i
Is there a history or evidence of the following conditions? Yes No If no, go to section 3g, Blood pressure Image: Solution 1 and Solution		Yes	No	I
Is there a history or evidence of the following conditions? Yes No If no, go to section 3g, Blood pressure Image: Social	f Cardiac channelopathies			
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Have any cardiac investigations been undertaken or planned? Yes No If no, go to section 4, Psychiatric illness If yes, please answer questions 1 to 5. 1. Is there a history of the following: Yes No (a) left bundle branch block (LBBB)? Image: Compare the section of the section o	 If resting blood pressure is 180 mm/Hg systolic or and/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the of the 3 readings in the box provided. I. Please record today's best resting blood pressure reading. 2. Is the applicant on anti-hypertensive treatment? If yes, please provide three previous readings 	a furthe best		
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 (a) left bundle branch block (LBBB)? (b) right bundle branch block (RBBB)? (c) paced rhythm? If yes to (a), (b) or (c), please give details in section 9, page 6. lote: If yes to questions 2 to 5, please give dates in the boxes rovided, give details in section 9, page 6. 2. Has an exercise ECG been undertaken Yes No 	 If resting blood pressure is 180 mm/Hg systolic or and/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the 3 readings in the box provided. 1. Please record today's best resting blood pressure reading. 2. Is the applicant on anti-hypertensive treatment? If yes, please provide three previous readings with dates if available. / / 1. Do to the 10 mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the 2 readings in the box provided. 1. Please record today's best resting blood pressure reading. / /<td>a furthe best</td><td></td><td></td>	a furthe best		
section 9, page 6. lote: If yes to questions 2 to 5, please give dates in the boxes rovided, give details in section 9, page 6. 2. Has an exercise ECG been undertaken Yes No	 If resting blood pressure is 180 mm/Hg systolic or and/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the 3 readings in the box provided. I. Please record today's best resting blood pressure reading. 2. Is the applicant on anti-hypertensive treatment? If yes, please provide three previous readings with dates if available. / /<	Yes	No	
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3.	 Has an echocardiogram been undertaken (or planned)? (a) If undertaken, is or was the left ejection fraction greater than or equal to 40%? 	Yes	No
4.	Has a coronary angiogram been undertaken (or planned)?	Yes	No
5.	Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?	Yes	No
4	Psychiatric illness		
im If r	there any significant mental illness or cognitive pairment likely to affect safe driving? no, go to section 5, Substance misuse ves, please answer all questions below. Significant psychiatric disorder within the past 6 months? If yes, please confirm condition.	Yes Yes	No No
2.	Psychosis or hypomania/mania within the	Yes	No
	past 12 months, including psychotic depression?		
3.	(a) Dementia or cognitive impairment?(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?	Yes	No
5	Substance misuse		
or	there a history of drug/alcohol misuse dependence? 10, go to section 6, Sleep disorders	Yes	No
	ves, please answer all questions below.		
		Yes	No
lf y	ves, please answer all questions below. Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental	this whic	h
lf y 1.	ves, please answer all questions below. Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? If there is a history of an alcohol use disorder, has been associated with any of the following features	this	
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Date of birth

6 Sleep disorders

1. Is there a history or evidence of Obstructive Yes No Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?

If no, go to section 7, Other medical conditions. If yes, please give diagnosis and answer all questions below.

a)	If Obstructive Sleep Apnoea Syndrome, J	please
	indicate the severity:	

Mild (AHI <15) Moderate (AHI 15 - 29) Severe (AHI >29) Not known

If another measurement other than AHI is used, it must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9 page 6, Further details.

b) Please answer questions (i) to (iv) for **all** sleep conditions.

(i)	Date of diagnosis:) I L		41	4	1		Yes	No
(ii)	Is it controlled succe	essf	ully	?					
(iii)	Is applicant complia	nt v	vith	trea	tme	nt?			Ē
(iv)	Date of last review.	D	D	M	M	Y	Y		

7 Other medical conditions

1.	Is there a history or evidence of narcolepsy?	Yes	No
2.	Is there any impairment resulting from either a physical or non-physical medical condition which is likely to affect the ability to control a vehicle?	Yes	No
	If yes, please provide information in section 9,	page	6.

3.	Is there a history of bronchogenic	Yes
	carcinoma or other malignant tumour	
	with a significant liability to metastasise cerebrally?	

4.	Is there any illness that may cause	Yes
	significant fatigue or cachexia that affects	
	safe driving?	

5.	Does the applicant have a history	Yes		
	of liver disease of any origin?			
	If yes, is this the result of alcohol misuse?			
	If yes, please give details in section 9, page 6	5.		

6.	Is there a history of renal failure?		
	If yes, please give details in section 9, page 6.		

Applicant's full name

 Does the applicant have severe symptomatic Yes respiratory disease causing chronic hypoxia? No

No

No

Yes

Does the applicant have any other medical condition that could affect safe driving?
 If yes, please provide details in section 9, page 6.

8 Medication

Is the applicant currently prescribed any of the following medication:

- (a) Anti-seizure?
- (b) Clozapine?
- (c) Sulphonylurea or a Glinide?
- (d) Insulin?

9 Further details

Do not send any notes not related to fitness to drive. Use the space below to provide any additional information.

No

No

No

No

Yes

9 Further details (continued)

10 Consultants' details

Please provide details of type of specialists or consultants, including address.
Consultant in
Reason for attendance
Name
Address
Date of last appointment:
Consultant in
Reason for attendance
Name
Address
Date of last appointment:
If more consultants seen give details on a separate sheet.
 11 Examining doctor's signature and stamp To be filled in by the doctor carrying out the examination.
Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this.
I confirm that this report was filled in by me at examination and I have taken the applicant's history into account. I also confirm that I am currently GMC registered and licensed to practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK. FIT / UNFIT (delete as appropriate) to drive with group 2 entitlement. Signature of examining doctor
Date of signature
Doctor's stamp
Date of birth

The applicant must fill in this page

Applicant's declaration

You **must** fill in this section and **must not** alter it in any way.

Please read the following important information carefully then sign to confirm the statements below.

Important information about fitness to drive

As part of the investigation into your fitness to drive, we may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness to drive. Also, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. Panel members must adhere strictly to the principle of confidentiality.

Declaration

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The Council may be statutorily required to supply any information you provide, to other bodies exercising functions of a public nature or the prevention and detection of fraud. For further information see http://runymede.gov.uk/datamatching. Data Protection and Privacy Any data supplied by you on this form will be processed in accordance with the General Data Protection Regulations, in supplying it you consent to the Council process is supplied. All personal information provided will be treated in the strictest confidence and will only be used by the Council or disclosed to others for a purpose permitted by law. Data is deleted in accordance with our data retention policy. We are committed to protecting your privacy when you use our services, the privacy policy explains how we use information about you and how we protect your privacy, this is published on our web site www.runnymede.gov.uk

Name Signature Date

I authorise Runnymede Borough Council to correspond with medical professionals via electronic channels (fax and/or email)

Yes

Yes

Yes		No	
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Checklist

- Have you signed and dated the declaration?
- Have you checked that the optician, optometrist or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?
 When complete please return to the Taxi Licensing Officer at Runnymede Borough Council.

Important

This report is valid for 3 months from the date the doctor, optician or optometrist signs it.

Updated March 2025