

RIBBLE VALLEY BOROUGH COUNCIL

MANDATORY GROUP 2 MEDICAL CERTIFICATE TO CERTIFY THAT AN APPLICANT FOR A HACKNEY CARRIAGE / PRIVATE HIRE DRIVER'S LICENCE IS FIT TO DRIVE THE PUBLIC

Note to Applicant

THIS MEDICAL CAN ONLY BE COMPLETED BY YOUR <u>OWN GENERAL PRACTITIONER</u> WITH WHOM YOU ARE REGISTERED WITH OR ANY OTHER GP WITHIN THE SAME PRACTICE WHO HAS <u>FULL ACCESS</u> TO YOUR RECORDS.

YOU ARE RESPONSIBLE FOR ANY FEES CHARGED BY YOUR DOCTOR

Note to Doctor

YOU SHOULD BE AWARE THAT "MEDICAL ASPECTS OF FITNESS TO DRIVE" PUBLISHED BY THE MEDICAL COMMISSION ON ACCIDENT PREVENTION IN 1995 RECOMMENDED THAT THE GROUP 2 MEDICAL STANDARDS APPLIED BY DVLA IN RELATION TO BUS AND LORRY DRIVERS, SHOULD ALSO BE APPLIED BY LOCAL AUTHORITIES TO TAXI DRIVERS.

DVLA INFORMATION LEAFLET INF4D MAY BE USED AS A REFERENCE DOCUMENT AND CAN BE VIEWED ONLINE AT HTTP://WWW.DVLA.GOV.UK/FORMS/PDF/INF4D.PDF

IT IS RIBBLE VALLEY BOROUGH COUNCIL'S CONDITIONS THAT A MANDATORY GROUP 2 MEDICAL BE IN FORCE

SECTION 1 – THE APPLICANT

Name of Applicant	
Home Address	
Date of Birth	

Medical Examination Report Part 2 – The Patient

weight (kg/ st)		
height (cms/ ft)		
Please give details of smoking habits, if		
any		
Please give number of alcohol units		
taken each week		
Is the urine sample taken, positive for Glucose?	YES ■	NO =
Is the applicant currently seeing a	YES ■	NO ■
specialist or consultant ?		
Current medication including exact		
dosage and reason for each treatment		
	Continue on Page 6	if necessary
VIS	ION	
Is the visual acuity at least 6/9 in the	YES ■	NO ■
better eye and at least 6/12 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	YES •	NO ■
to achieve this standard?		
If YES, is the uncorrected acuity at least	YES •	NO ■
3/ 60 in the right eye?		
(3/60 being the ability to read the 6/60 line of the		
full size 6m Snellen chart at 3 metres)		
If YES, is the uncorrected acuity at least	YES •	NO
3/ 60 in the left eye?		
(3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)		
If YES, is the correction well tolerated	YES ■	NO ■
Please state the visual acuities of each	LEFT	RIGHT
	LEFT	niditi
UNCORRECTED eye in terms of the 6m Snellen chart.		
Please convert any 3 metre readings to the 6 metre equivalent.		
Please state the visual acuities of each	LEFT	RIGHT
	LLI I	nigiti
CORRECTED eye in terms of the 6m		
Snellen chart (if applicable)		
Please convert any 3 metre readings to		
the 6 metre equivalent. Is there a defect in his/her binocular field	YES ■	NO ■
	I EO	NO I
of vision (central and/or peripheral)?	YES ■	NO ■
Is there diplopia? (controlled or uncontrolled)?	I EO	NO I
	YES ■	NO ■
Does the applicant have any other	I EO II	INO ■

ophthalmic condition?		
NERVOUS	S SYSTEM	
Has the applicant had any form of epileptic attack?	YES ■	NO ■
(a) If Yes, please give date of last attack	,	
(b) If treated, please give date when treatment ceased		
Is there a history of blackout or impaired consciousness within the last 5 years?	YES ■	NO ■
Does the applicant suffer from	YES ■	NO ■
narcolepsy / cataplexy? Is there a history of, or evidence of any of	YES ■	NO ■
the conditions below?Stroke/ TIA (please delete as	If yes please give details at the end of	
appropriate)Sudden and disabling	this report	
dizziness/vertigo within the last 1 year with a liability to recur		
 Subarachnoid haemorrhage 		
 Serious head injury within the last 10 years 		
 Brain tumour, either benign or malignant, primary or secondary 		
Other brain surgery		
 Chronic neurological disorders e.g. Parkinson's disease, Multiple 		
Sclerosis • Dementia or cognitive impairment		
DIABETES	MELLITUS	
Does the applicant have diabetes mellitus?	YES ■ If yes, continue below	NO In It no, skip the remainder of this section.
Is the diabetes managed by:- (a) Insulin?	YES ■ If YES, please give date started on insulin	NO ■
(b) Oral hypoglycaemic agents and diet?	YES ■	NO ■
(c) Diet only? Does the patient test blood glucose at	YES ■ YES ■	NO ■
least twice every day?		
Is there evidence of loss of visual field?	YES ■ YES ■	NO ■
Is there evidence of severe peripheral neuropathy, sufficient to impair limb function for safe driving?	153	NO ■
Is there evidence of diminished/absent awareness of hypoglycaemia?	YES ■	NO ■
Has there been laser treatment for	YES •	NO ■

wating an ather-0	I I	
retinopathy?	YES ■	NO ■
Is there a history of hypoglycaemia during waking hours in the last 12	165	NO I
months requiring assistance from a third		
party?		
PSYCHIATE	RIC ILLNESS	
Is there a history of, or evidence of any of the conditions listed below?	YES ■	NO ■
	If yes please give	If no, skip the
Significant psychiatric disorder within the past 6 months	details at the end	remainder of this
within the past 6 months	of this report	section.
 A psychotic illness within the past 3 years including psychotic 		300110111
depression		
Persistent alcohol misuse in the		
past 12 months		
 Alcohol dependency in the past 3 		
years		
 Persistent drug misuse in the past 		
12 months		
 Drug dependency in the past 3 		
years		
•		
CAR	DIAC	
Is there a history of, or evidence of,	YES ■	NO ■
coronary artery disease?		
,	If yes please give	If no, skip the
	details below and a	
	the end of this	section.
Myocardial Infarction?	report	NO ■
wyocardiai iiiiaiciioii:	123	
Coronary artery by-pass graft?	YES ■	NO ■
Coronary Angioplasty (with or without	YES ■	NO ■
stent)?		
Has the applicant suffered from Angina?	YES ■	NO ■
Is there a history of, or evidence of,	YES ■	NO ■
cardiac arrhythmia?		
Is there any history or evidence of	YES ■	NO ■
PRIPHERAL ARTERIAL DISEASE		
		•
Is there any history or evidence of	YES ■	NO ■
AORTIC ANEURYSM		
AORTIC ANEURYSM Is there any history or evidence of	YES ■	NO NO
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA	YES ■	NO ■
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of		
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of Valvular or congenital heart disease?	YES YES	NO NO
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of Valvular or congenital heart disease? Does the applicant have a history of ANY	YES ■	NO ■
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of Valvular or congenital heart disease?	YES YES	NO NO
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of Valvular or congenital heart disease? Does the applicant have a history of ANY of the following conditions:	YES YES	NO NO
Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of Valvular or congenital heart disease? Does the applicant have a history of ANY of the following conditions: • a history of, or evidence of heart	YES YES	NO NO
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of Valvular or congenital heart disease? Does the applicant have a history of ANY of the following conditions:	YES YES	NO NO
AORTIC ANEURYSM Is there any history or evidence of DISSECTION OF THE AORTA Is there any history or evidence of Valvular or congenital heart disease? Does the applicant have a history of ANY of the following conditions: • a history of, or evidence of heart	YES YES	NO NO

a heart or heart/lung transplant?		
CARDIAC INV	ESTIGATIONS	
Has a resting ECG been undertaken?	YES •	NO ■
rias a resting Low been undertaken:	If yes, continue below	If no, skip the remainder of this section.
If YES, does it show pathological Q waves?	YES ■	NO ■
If YES, does it show left bundle branch block?	YES ■	NO ■
Has an exercise ECG been undertaken (or planned)?	YES ■	NO ■
Has an echocardiogram been undertaken (or planned)?	YES ■	NO ■
Has a coronary angiogram been undertaken (or planned)?	YES ■	NO ■
Has a 24 hour ECG tape been undertaken (or planned)?	YES ■	NO ■
Has a myocardial perfusion imaging scan been undertaken (or planned)?	YES ■	NO ■
BLOOD P	RESSURE	
Is today's resting systolic pressure 180mm Hg or greater?	YES ■	NO ■
Is today's resting diastolic pressure 100mm Hg or greater?	YES ■	NO ■
Is the applicant on anti-hypertensive treatment?	YES ■	NO ■
Please give todays BP reading		
GENERAL	L HEALTH	
Is there currently a disability of the spine or limbs, likely to impair control of the vehicle?	YES ■	NO ■
Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally?	YES ■	NO ■
Is the applicant profoundly deaf?	YES •	NO ■
If YES, is he/she able to communicate in the event of an emergency by speech or by using a device, e.g. a MINICOM/ text phone?	YES ■	NO ■
Is there a history of either renal or hepatic failure?	YES ■	NO ■
Does the applicant have sleep apnoea syndrome	YES ■	NO ■
If YES, has it been controlled successfully?	YES ■	NO ■
	YES ■	NO ■
-		•

Is there any other Medical Condition, causing excessive daytime sleepiness	YES IN IT YES, please give full details at the end of this report.	NO ■
Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	YES ■	NO ■
Does any medication currently taken cause the applicant side effects which impair his/ her safe driving?	YES ■	NO ■
Is the applicant sufficiently active for the performance of his/her duties?	YES ■	NO ■

ADDITIONAL INFORMATION

To:
The Taxi Licensing Officer, Ribble Valley Borough Council, Council Offices, Church Walk, Clitheroe, Lancashire, BB7 2RA
I certify that :
I have this day examined the above named person and have completed the above medical certificate. The answers are true to the best of my knowledge and belief.
The above named person is registered with this Doctors Practice and I have checked and have had access to the above-named patient's medical history.
I CONSIDER THE APPLICANT TO BE MEDICALLY \overline{FIT} / \overline{UNFIT} # to act as driver of a Hackney Carriage or Private Hire Vehicle to carry the public for commercial gain.
(please delete one)

I CONSIDER THE APPLICANT SHOULD BE SUBJECT TO A FURTHER MEDICAL EXAMINATION IN

5 years

3 years

1 year

other (PLEASE SPECIFY)

Signature of Qualified & Registered Medical Practitioner

Date

SURGERY STAMP:

LICENSING UNIT ONLY - PLEASE DO NOT WRITE IN THE SPACE BELOW