This template can be used until 31 December 2026, subject to legal amendments.

CITY OF WOLVERHAMPTON COUNCIL

South Staffordshire Council

Hackney Carriage and Private Hire Driver Medical Certificate

To the applicant: take this certificate to your medical professional with:

1. **full** medical records from your GP
2. original **passport** or **driving licence**
3. utility bill or bank statement or birth certificate or marriage/civil partnership certificate.

Applicant details			
Full name			
Date of birth		**Age**	
Address			
Postcode			
Applicant's signature			
(To be signed in the presence of the examining medical professional signing this certificate)			

To the GMC registered medical professional: by signing this certificate, you are confirming that you have verified the identity of the above applicant having checked their provided documents (above). You are assessing fitness to drive at DVLA Group 2 Standard. A guide is available online at https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals. This certificate **must be completed in person** and not remotely. You must include the **full Group 2 Medical Examination Report (D4**), appended to this certificate. The medical examination frequency is at least every 5 years after the applicant's 45th birthday. Once the age of 65 is reached, a medical certificate must be produced at least every year. If your opinion is that they require examination sooner, please confirm the date you think they should next undergo medical examination (optional): ___ ___ / ___ ___ / ___ ___ ___ ___

Medical Professional's Report and Declaration	
I certify that I have on this day **examined the applicant**, who **signed this form in my physical presence** and showed **two forms of identification** as indicated above and provided me with their **full medical records** obtained within the last month for which I have reviewed to certify their medical fitness to DVLA Group 2 Standards and **completed the attached D4 Form** and I declare that, for the purposes of driving a hackney carriage or private hire vehicle, they are: (**tick one only**) ❑ **medically fit** ❑ **medically unfit**	
Examination date	
Examining medical professional's full name	
Examining medical professional's signature	
GMC reference number	
Practice address and phone number or practice/company stamp (no disclaimers)	

Please note, this certificate is valid for driver licence applications made within four months from the date of examination.

Driver & Vehicle Licensing Agency

Medical examination report
for a Group 2 (bus or lorry) 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.

D4

Applicants: you must fill in all grey sections of this report. This includes the section below, your full name and date of birth at the end of each page and the declaration on page 8.

Important: This report is only valid for 4 months from date of examination.

Name

Date of birth D D M M Y Y

Address

Postcode

Contact number (optional)

Email address (optional)

Date first licensed to drive a bus or lorry

D D M M Y Y

If you do not want to receive survey invitations by email from DVLA, please tick box ☐

Your doctor's details (only fill in **if different** from examining doctor's details)

GP's name

Practice address

Postcode

Contact number

Email address

Medical professionals must fill in all green sections on this report.

Important information for doctors carrying out examinations.

Before you fill in this report, you must check the applicant's identity and decide if you are able to fill in the Vision assessment on page 2. If you are unable to do this, you must inform the applicant that they will need to ask an optician or optometrist to fill in the Vision assessment.

Examining medical professional

Name

Has a company employed you or booked you to carry out this examination? Yes ☐ No ☐

If yes, you **must** give the company's details below.

If no, you must give your practice address details below. (Refer to section C of INF4D.)

Company or practice address

Postcode

Company or practice contact number

Company or practice email address

GMC registration number

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)

Do you have access to the applicant's full medical record? Yes ☐ No ☐

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

Driver & Vehicle Licensing Agency

Medical examination report
Vision assessment
To be filled in by an optician, optometrist or doctor

D4

1. Please confirm (✓) the scale you are using to express the applicant's visual acuities.

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. 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 by an optician.

R ☐ L ☐

(b) Are corrective lenses worn for driving? Yes ☐ No ☐
If no, go to Q3.

If yes, please provide the visual acuities using 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 dioptres in any meridian of either lens? Yes ☐ No ☐

(e) If correction is worn for driving, is it well tolerated? Yes ☐ No ☐
If no, please give full details in Q8.

3. Is there a known visual field defect? Yes ☐ No ☐

4. Are there any medical conditions which might result in a visual field defect? Yes ☐ No ☐

(a) If yes, has a visual field defect been excluded? Yes ☐ No ☐

(b) Please provide the condition:

If formal visual field testing is considered necessary, DVLA will commission this at a later date.

5. Is there diplopia? Yes ☐ No ☐

(a) Is it controlled? Yes ☐ No ☐

Please indicate below and give full details in Q8.

Patch or glasses with frosted glass ☐ Glasses with/without prism ☐ Other (if other please provide details) ☐

6. Does the applicant report symptoms of any of the following that impairs their ability to drive? Yes ☐ No ☐

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 ☐

7. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? Yes ☐ No ☐

If yes, please give full details in Q8 below.

8. Details or additional information

Name of examining doctor, optician or optometrist undertaking vision assessment

I confirm that this report was filled in by me at examination and the applicant's history has been taken into consideration.

Signature of examining doctor, optician or optometrist

Date of signature D D M M Y Y

Please provide your GOC or GMC number

Doctor, optometrist or optician's stamp

Applicant's full name **Date of birth** D D M M Y Y

Please do not detach this page

Driver & Vehicle Licensing Agency

Medical examination report

Medical assessment

Must be filled in by a doctor

D4

1 Neurological disorders

Please tick ✓ the appropriate boxes

Does the applicant have a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? Yes ☐ No ☐

If no, go to section 2, Diabetes mellitus

If yes, please answer all questions below.

	Yes	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 D D M M Y Y		
Last episode D D M M Y Y		
(c) Is the applicant currently on anti-seizure medication?	☐	☐
(d) If no longer treated, when did treatment end? D D M M Y Y		
(e) Has the applicant had a brain scan? If yes, please give details in section 9, page 6.	☐	☐
2. Has the applicant experienced any dissociative/functional seizures?	☐	☐
(a) If yes, please give date of most recent episode. D D M M Y Y		
(b) If yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	☐	☐
3. Stroke or TIA?	☐	☐
If yes, give date. D D M M Y Y		
(a) Has there been a **full** recovery?	☐	☐
(b) Has a carotid ultrasound been undertaken?	☐	☐
(c) If yes, was the carotid artery stenosis >50% in either carotid artery?	☐	☐
(d) Is there a history of multiple strokes/TIAs?	☐	☐
4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?	☐	☐
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)?	☐	☐
10. Parkinson's disease?	☐	☐
11. Blackout, impaired consciousness or loss of awareness within the last 5 years?	☐	☐

2 Diabetes mellitus

	Yes	No
Does the applicant have diabetes mellitus?	☐	☐
If no, go to section 3, Cardiac		
If yes, please answer all questions below.		
1. Is the diabetes treated by:		
(a) Insulin? If no, go to 1c	☐	☐
If yes, please give date started on insulin. D D M M Y Y		
(b) Are there at least 6 continuous weeks of blood glucose readings stored on a memory meter or meters?	☐	☐
If no, please give details in section 9, page 6.		
(c) Other injectable treatments?	☐	☐
(d) A Sulphonylurea or a Glinide?	☐	☐
(e) Oral hypoglycaemic agents and diet?	☐	☐
(f) Diet only?	☐	☐
2. (a) Does the applicant test blood glucose at least twice every day?	☐	☐
(b) Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every 2 hours whilst driving)?	☐	☐
(c) Does the applicant keep fast-acting carbohydrate within easy reach whilst driving?	☐	☐
(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?	☐	☐
3. (a) Has the applicant ever had a hypoglycaemic episode?	☐	☐
(b) Is there full awareness of hypoglycaemia?	☐	☐
4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?	☐	☐
If yes, please give details and dates below.		
D D M M Y Y		
D D M M Y Y		
D D M M Y Y		
5. Has there been laser treatment or intra-vitreal treatment for retinopathy?	☐	☐
If yes, please give most recent date of treatment. D D M M Y Y		

Applicant's full name | **Date of birth** D D M M Y Y

3 Cardiac

a Coronary artery disease

Is there a history or evidence of coronary artery disease? Yes ☐ No ☐

If no, go to section 3b, Cardiac arrhythmia

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. D D M M Y Y

2. Acute coronary syndrome including myocardial infarction? Yes ☐ No ☐

If yes, please give date. D D M M Y Y

3. Coronary angioplasty (PCI)? Yes ☐ No ☐

If yes, please give date of most recent intervention. D D M M Y Y

4. Coronary artery bypass graft surgery? Yes ☐ No ☐

If yes, please give date. D D M M Y Y

5. If yes to any of the above, are there any 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. Yes ☐ No ☐

b Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia? Yes ☐ No ☐

If no, go to section 3c, Peripheral arterial disease

If yes, please answer all questions below.

1. Has there been a significant disturbance of cardiac rhythm causing/likely to cause incapacity in the last 5 years? Yes ☐ No ☐

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes ☐ No ☐

3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes ☐ No ☐

4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes ☐ No ☐

If yes:

(a) Please give date of implantation. D D M M Y Y

(b) Is the applicant free of the symptoms that caused the device to be fitted? ☐ ☐

(c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? Yes ☐ No ☐

If no, go to section 3d, Valvular/congenital heart disease

If yes, please answer all questions below.

1. Peripheral arterial disease? (excluding Buerger's disease) Yes ☐ No ☐

2. Does the applicant have claudication? Yes ☐ No ☐

If yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT? ☐ ☐

3. Aortic aneurysm? Yes ☐ No ☐

If yes:

(a) Site of aneurysm: Thoracic ☐ Abdominal ☐

(b) Has it been repaired successfully? ☐ ☐

(c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.

. cm D D M M Y Y

4. (a) Dissection of aorta? Yes ☐ No ☐

(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.

5. Is there a history of Marfan's disease? Yes ☐ No ☐

(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

d Valvular/congenital heart disease

Is there a history or evidence of valvular or congenital heart disease? Yes ☐ No ☐

If no, go to section 3e, Cardiac other

If yes, please answer all questions below.

1. Is there a history of congenital heart disease? Yes ☐ No ☐

2. Is there a history of heart valve disease? Yes ☐ No ☐

(a) If yes, are they symptomatic? ☐ ☐

3. Is there a history of aortic stenosis? Yes ☐ No ☐

If yes, please provide relevant reports (including echocardiogram).

4. Has there been any progression (either clinically or on scans etc) since the last licence application? Yes ☐ No ☐

Applicant's full name **Date of birth** D D M M Y Y

e Cardiac other

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 ☐
If yes, please give details in section 9, page 6.

3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes ☐ No ☐

4. A heart or heart/lung transplant? Yes ☐ No ☐

5. Evidence or history of pulmonary arterial hypertension? Yes ☐ No ☐

f Cardiac channelopathies

Is there a history or evidence of the following conditions? Yes ☐ No ☐
If no, go to section 3g, Blood pressure

1. Brugada syndrome? Yes ☐ No ☐

2. Long QT syndrome? Yes ☐ No ☐
If yes to either, please give details in section 9, page 6.

g Blood pressure

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 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. /

2. Is the applicant on anti-hypertensive treatment? Yes ☐ No ☐
If yes, please provide three previous readings with dates if available.

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

h Cardiac investigations

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)? Yes ☐ No ☐
   (b) right bundle branch block (RBBB)? Yes ☐ No ☐
   (c) paced rhythm? Yes ☐ No ☐
   If yes to (a), (b) or (c), please give details in section 9, page 6.

Note: If yes to questions 2 to 5, please give dates in the boxes provided, give details in section 9, page 6.

2. Has an exercise ECG been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐

3. Has an echocardiogram been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐
   (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)? D D M M Y Y Yes ☐ No ☐

5. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? D D M M Y Y Yes ☐ No ☐

4 Psychiatric illness

Is there any significant mental illness or cognitive impairment likely to affect safe driving? Yes ☐ No ☐
If no, go to section 5, Substance misuse
If yes, please answer all questions below.

1. Significant psychiatric disorder within the past 6 months? If yes, please confirm condition. Yes ☐ No ☐

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes ☐ No ☐

3. (a) Dementia or cognitive impairment? Yes ☐ No ☐
   (b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses? Yes ☐ No ☐

5 Substance misuse

Is there a history of drug/alcohol misuse or dependence? Yes ☐ No ☐
If no, go to section 6, Sleep disorders
If yes, please answer all questions below.

1. Is there a history of an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? Yes ☐ No ☐

2. If there is a history of an alcohol use disorder, has this been associated with any of the following features which indicate a physiological dependence on alcohol:
   (a) Required medical assisted withdrawal? Yes ☐ No ☐
   Date treatment ended: D D M M Y Y
   (b) Alcohol withdrawal seizure? Yes ☐ No ☐
   Date of last event: D D M M Y Y

3. Based on their clinical record and/or account of drinking provided to you, is their alcohol consumption:
   (a) Abstinent? Yes ☐ No ☐ Don't know ☐
   If yes, for how long:
   (b) Controlled? Yes ☐ No ☐ Don't know ☐
   If yes, for how long:

4. Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? Yes ☐ No ☐
   (a) If yes, the type of substance misused?
   (b) Is it controlled? Yes ☐ No ☐
   (c) Has the applicant undertaken an opiate treatment programme? Yes ☐ No ☐
   If yes, give date started D D M M Y Y

Applicant's full name **Date of birth** D D M M Y Y

6 Sleep disorders

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

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, 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: D D M M Y Y

	Yes	No
(ii) Is it controlled successfully?	☐	☐
(iii) Is applicant compliant with treatment?	☐	☐

(iv) Date of last review. D D M M Y Y

7 Other medical conditions

	Yes	No
1. Is there a history or evidence of narcolepsy?	☐	☐
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? If yes, please provide information in section 9, page 6.	☐	☐
3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?	☐	☐
4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?	☐	☐
5. Does the applicant have a history 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.		
6. Is there a history of renal failure? If yes, please give details in section 9, page 6.	☐	☐
7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
8. 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:

	Yes	No
(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.

Applicant's full name **Date of birth** D D M M Y Y

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: D D M M Y Y

Consultant in
Reason for attendance
Name
Address

Date of last appointment: D D M M Y Y

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.

Signature of examining doctor

Date of signature D D M M Y Y

Doctor's stamp

Applicant's full name

Date of birth D D M M Y Y

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 enquiries into your fitness to drive, we (DVLA) may need you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.

These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.

Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory panel members.

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

I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution.

Name

Signature

Date

I authorise the Secretary of State to correspond with medical professionals via electronic channels (email)

Yes ☐ **No** ☐

Checklist

- Have you signed and dated the declaration? **Yes** ☐
- 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? **Yes** ☐

Important

This report is valid for 4 months from the date the doctor, optician or optometrist signs it.

Please return it together with your application form.
