Hackney Carriage and Private Hire Vehicle Driver Medical Examination and Certificate

This medical examination and certificate form ("the medical") is required by Cardiff Council to determine whether the applicant or licence holder ("the applicant") is medically fit to drive hackney carriage and private hire vehicles.

Completion Instructions

- **Section 1:** To be completed by the applicant.
- **Section 2:** To be completed by a medical practitioner registered with the UK General Medical Council.
- **Vision section:** May be completed by an optician or optometrist registered with the General Optical Council.

Medical Assessment

This assessment will not be processed by the DVLA; it is for local authority consideration only. The medical practitioner must examine the applicant in person and review their NHS Summary Medical Records before completing the certificate. If unable to complete the declaration, further tests or specialist referrals may be required.

Fees and Charges

This medical is not available on the NHS. Fees, including those for any referrals, are payable directly to the medical practitioner. Fees are non-refundable if an application is refused.

Data Protection

Completed medicals are held by Cardiff Council in accordance with its data policy and privacy statement.

Standards and Guidance

Medical practitioners must follow the current DVLA D4 Medical Examination Report guidance, available at www.gov.uk/government/publications/d4-medical-examiner-report-for-a-lorry-or-bus-driving-licence. Cardiff Council requires all applicants to meet **Group 2 Medical Standards, as drivers transport passengers and typically drive more intensively** than Group 1 drivers. Applicants unsure about medical or eyesight standards should consult their doctor or optician before arranging the examination.

Further Guidance

View the Welsh Government guidance at www.gov.wales/taxi-and-private-hire-vehicles-licensing-guidance and our local authority policies at www.cardiff.gov.uk/ENG/Business/Licences-and-permits/Pages/default.aspx.

Final Instructions

The practitioner must complete the certificate on page 11. Provided there are no changes in health, the certificate remains valid for **four months** from the date of completion.

SECTION 1 - TO BE COMPLETED BY THE APPLICANT
APPLICANT DETAILS AND CONSENT

The applicant must enter name and date of birth at the end of each page.

Name	
Date of birth	D D M M Y Y
Address Postcode	
Contact number	
GP's name	
Practice address Postcode	
Practice contact number	

APPLICANT'S CONSENT AND DECLARATION

I declare that, to best of my knowledge, I am giving a correct account of my medical health to the medical practitioner completing the medical. I give consent and authorise my doctor to release reports to Cardiff Council about my medical condition upon request."

Applicant's Signature	
Date	

SECTION 2 - TO BE COMPLETED BY THE MEDICAL PRACTITIONER

THE MEDICAL EXAMINATION AND CERTIFICATE

Before the Medical Professional completes section 2, you must check the applicant's identity and decide if you are able to fill in the vision assessment on page 5. 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. A medical practitioner may not complete the declaration to certify the applicant meets group 2 medical standards without a vision assessment, for consideration.

EXAMINING MEDICAL PROFESSIONAL COMPLETING THE EXAMINATION

Name	
Practice/ company name	
Practice/ company registered address Postcode	
Contact number	
Email address	
GMC registration number	

I can confirm that I have checked the applicant's documents to prove their identity.	
Signature of Medical Practitioner	
Applicant's weight (kg)	
Applicant's height (cm)	
Number of alcohol units consumed weekly	Units per week
Does the applicant smoke?	Yes ☐ No ☐
Do you have access to the applicant's HNS summary medical records?	Yes ☐ No ☐

Applicant's Name **DOB**

Vision Assessment – To be completed by an optician, optometrist or doctor

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

Snellen ☐ Snellen expressed as a decimal ☐

LogMAR ☐

2.The vision 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 the 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? If no, go to Q3 — Yes ☐ No ☐

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. Aare 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:

☐

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 ☐

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 the examination and the applicant's NHS summary records has been taken into consideration.
Signature of examining doctor, optician or optometrist:

Date of signature D D M M Y Y

Please provide your GMC or GOC number:

Doctor, optometrist or optician's stamp:

Applicant's Name ☐ **DOB** ☐

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.

1. Has the applicant had any form of seizure?

Yes ☐ No ☐

a) Has the applicant had more than one seizure episode?

Yes ☐ No ☐

b) If Yes, give the date of the 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 any anti-seizure medication?

Yes ☐ No ☐

(d) If no longer treated, when did treatment end?

D D M M Y Y

(e) Has the applicant had a brain scan?

Yes ☐ No ☐

If Yes, please give details in section 9, page 9.

2. Has the applicant experienced dissociative/functional seizures?

Yes ☐ No ☐

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?

Yes ☐ No ☐

	Yes	No
3. Stroke or TIA?		
If Yes, give date. D D M M Y Y		
a) Has there been a full recovery?		
b) Has 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 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 managed by: a) Insulin? (If No, go to C1)		
If Yes, 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 9.		
c) Other injectable treatments?		
d) 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 while driving)?		
c) Does the applicant keep fast-acting carbohydrate within easy reach when 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) If Yes, 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

	Yes	No
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 Name _____ **DOB** _____

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 (CPI)? Yes ☐ No ☐

If Yes, please give date of the 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 pacemaker (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? Yes ☐ No ☐

c) Does the applicant attend a pacemaker clinic regularly? Yes ☐ No ☐

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 EET? Yes ☐ No ☐

3. Aortic aneurysm? Yes ☐ No ☐

If Yes:

a) Site of aneurysm: Thoracic ☐ Abdominal ☐

b) Has it been repaired successfully? Yes ☐ No ☐

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? Yes ☐ No ☐

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

Yes ☐ No ☐

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? Yes ☐ No ☐

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

If yes, please consider 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 Name _____ **DOB** _____

e. Cardiac other

Is there a history or evidence of heart failure? Yes No

If No, go to section 3f, 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 9.

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

4. A heart or heart/lung transport? 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 9.

g. Blood pressure

All questions must be answered.
1. If resting blood pressure is 180mm/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 here: /

2. Is the applicant on anti-hypertensive treatment? Yes No

If Yes, please provide 3 previous readings with dates if available.

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

3. Does the blood pressure readings result in the applicant not meeting the group 2 medical fitness criteria? Yes No

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)?
b) right bundle branch block (RBBB)?
c) paced rhythm?

If Yes to a) b) c), please give details in section 9, page 9.

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

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

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

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
D D M M Y Y

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

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 12 months? If Yes, please confirm condition. Yes No

2. Psychosis or hypomania/mania within the 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?

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 misuse disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years?

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: Yes No
a) Required medical assisted withdrawal?
Date treatment ended: D D M M Y Y
b) Alcohol withdrawal seizure?
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
If Yes, please give the type of substance or substances misused:
a) Is it controlled? Yes No
b) Has the applicant undertaken an opiate treatment programme? Yes No D D M M Y Y

Applicant's Name **DOB**

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. We do not prescribe different measurements as this is a clinical issue.
Please give details in section 9, page 9.

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

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 Name _____ **DOB** _____

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 are seen, please give details on a separate sheet.

Applicant's Name | **DOB**

Hackney Carriage and Private Hire Vehicle Driver Medical Certificate

Please complete only one of the following boxes:

I CERTIFY THAT I have examined the above-named person, this person **meets** the group 2 standards of medical fitness, with regard to the current edition of the "D4 medical examination report information and notes" issued by the DVLA to the licensing of lorry and bus driver's, also required for licensed hackney carriage and private hire vehicle driver's licence. Signature of Medical Practitioner: _____ Date:	I CERTIFY THAT I have examined the above-named person, this person **does not meet** the group 2 standards of medical fitness, with regard to the current edition of the "D4 medical examination report information and notes" issued by the DVLA to the licensing of lorry and bus driver's, also required for licensed hackney carriage and private hire vehicle driver's licence. Signature of Medical Practitioner: _____ Date:

Please tick one of the following:

I am a General Practitioner at the practice where the applicant is registered and the applicant's NHS summary records were consulted before/during examination ☐

I am a Medical Practitioner conducting a private medical examination who has access to the applicant's NHS summary records and these records were consulted before/during examination ☐

I declare that the answers to all questions are true to the best of my knowledge and belief. I understand that it is an offence for the person completing this form to make a false statement or omit relevant details. If declaring an existing licence holder does NOT meet the group 2 standards, I will notify the local authority immediately: taxi@cardiff.gov.uk	
Medical Practitioner Full Name (Print):	
Registration number with the General Medical Council:	
Signature:	Date:
Surgery Stamp (if applicable):	

Applicant's Name _____ **DOB** _____