APPLICATION FOR HACKNEY CARRIAGE/PRIVATE HIRE DRIVER'S LICENCE

WHAT YOU HAVE TO DO

You may attend your own GP or any general practitioner (fee not known),or Cosmedica Clinic, Weavers Yard, Lane End Road, Bembridge Contact email enquiries@cosmedicaclinics.co.uk Tel no. 872456 fee £110.00.

***IMPORTANT** -YOU MUSTBRING YOUR GLASSES IF YOU WEAR THEM TO YOUR MEDICAL AND A COPY OF YOUR OPTICAL PRESCRIPTION WHETHER YOUR MEDICAL IS WITH YOUR GP OR AT OH AS DETAILS OF DIOPTRE MEASUREMENT IS REQUIRED*

If you choose to have your medical with someone other than your own GP, then you must obtain your full medical record/history and ensure that these are available to your chosen assessor at your appointment. The assessor is required to indicate on this form that they have had full sight of your medical records, and if we receive medical forms which indicate that a full medical history and records were not made available to them, then the Licensing Department will not be able to accept this as a reliable certificate of fitness and you will be required to have a further medical once you can provide your full records.

It is your responsibility to pay all medical and verification fees.

MEDICAL EXAMINATION – NOTES ABOUT FITNESS

Please read these notes before completing Part A of the form and making an appointment for a medical examination.

The Medical standards for Hackney Carriage/Private Hire Driver licences are higher than they are for ordinary driving licences. Some standards are explained in outline below. If you have any doubts about your fitness to drive, talk to your Doctor before you pay for a full examination.

1. **EPILEPTIC ATTACK**

   Applicants must **NOT** have a liability to epileptic seizures.
   This means that applicants must have been free of epileptic seizures for at least the last ten years and have not taken anti epileptic medication during this ten-year period. With such a liability the Council must refuse or revoke the licence.

2. **DIABETES**

   New applicants or existing drivers are assessed individually and will need to comply with the current DVLA Group 2 standards which can be viewed on the DVLA website.

3. **EYESIGHT**

   (I) Applicants for Passenger carrying vehicles must have:

- a visual acuity of at least 6/7.5 (decimal Snellen equivalent 0.8) in the better eye.
- a visual acuity of at least 6/60 (decimal Snellen equivalent 0.1) in the worse eye.

Corrective lenses may be worn to achieve this standard. Where lenses are worn to meet the minimum standards, they should have a corrective power of less than or equal to +8 dioptres.

(ii) Applicants are also barred if they have:

- uncontrolled diplopia (double vision) ***OR*** do not have a normal binocular field of vision

An Applicant (or existing licence holder) failing to meet the epilepsy, diabetes or eyesight regulations will be refused

4. Other medical conditions such as Angina, Heart Failure, a Heart attack may preclude you from qualifying for a Hackney Carriage/Private Hire Driver licence. If in doubt discuss your circumstances with your doctor before applying.

IMPORTANT

By law you must tell the Drivers Medical Branch, DVLC, Swansea SA99 1TU at once if you have any disability which could affect your driving. This includes mental as well as physical conditions.

You should also note that when you hold a Hackney Carriage/Private Driver's licence you must notify Licensing, Isle of Wight Council, County Hall, Newport, Isle of Wight P030 1UD if circumstances change and you develop any illness or disability which may affect your driving

MEDICAL REPORT

APPLICATION FOR HACKNEY CARRIAGE/PRIVATE HIRE DRIVER'S LICENCE

Applicants for Hackney Carriage/Private Hire Driver's Licence are required to have medical examinations as follows:-

- On grant of licence
- On renewal of the driver's licence, the applicant must submit evidence to the satisfaction of the Council that he or she is physically fit to drive.
- This condition applies from age 45 years and every 5(five) years thereafter until the age of 65 years when a medical certificate must be produced yearly thereafter.

NOTES FOR THE APPLICANT

The Doctor **WILL NOT** be able to give you this report free under the NHS. We therefore advise you to begin by reading the **NOTES ABOUT FITNESS** overleaf. If you have any doubts about your fitness, talk to the Doctor who will be completing the Report **BEFORE** requesting an examination.

Please complete **PART A** of this form.

Applicant's Details

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

Please make sure that you have printed your name and date of birth on each page before sending this form in.

Your Full Name	Date of Birth
Your address	Home Telephone No.
	Work/Daytime No.

About Your GP/Group Practice

GP/Group name	Telephone No
Address	How long have you been registered with this doctor or group practice?

Applicant's consent & declaration

This section MUST be completed and must NOT be altered in any way. Please read the following important information carefully then sign the statement below.

Important information about Consent: On occasion, as party of the investigation into your fitness to drive you may be required to undergo a medical examination or some form of practical assessment. In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. Only information relevant to the assessment of your fitness to drive will be released.

Consent & declaration

I authorise my Doctor(s) and Specialist(s) to release reports about my condition, and to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive. 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.

Signature: _____ Date: _____

NOTES FOR THE DOCTOR

This report is part of the application for a licence. The purpose of the report is to determine the applicant's fitness to drive a Hackney Carriage/Private Hire vehicle.

Do you have access to the applicant's full medical record? YES ☐ NO ☐

Please complete sections 1 - 8 of the report. The Council has medical criteria for a Hackney Carriage/Private Hire Licence, in line with the Group II Medical Standards of the DVLC. You may find it helpful to consult the Medical Commission on Accident Prevention booklet - Medical Aspects of Fitness to Drive.

Applicants who may be asymptomatic at the time of completion of this report and obtain a Hackney Carriage/Private Hire Driver's licence, who later show symptoms of a medical condition, should be advised to inform the Licensing Section of the Isle of Wight Council.

PART B Medical Report - to be completed by the Doctor
Please answer all questions

Please give the patient's weight (kg/st) _____ Height (cms/ft) _____

Please give details of smoking habits, if any _____

Please give number of alcohol units taken each week (1 unit = 8 grams/10ml alcohol) _____

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

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

	1	2	3
Name & Address			
Speciality			
Date last seen			
Current medication including exact dosage and reason for each treatment			

PLEASE TICK THE APPROPRIATE BOX(ES) ***YES NO***

Section 1 VISION

1. Is the visual acuity **at least** 6/7.5 (decimal Snellen equivalent 0.8) in the better eye and at least 6/60 (decimal Snellen equivalent 0.1) in the other?
   (Corrective lenses may be worn) as measured with the full size 6m Snellen chart ☐ ☐

2. If a correction is worn for driving, is it 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		**CORRECTED (using the prescription worn for driving)**	
Right	Left	Right	Left

4. Please give the best binocular acuity (with corrective lenses if worn) _____

5. If glasses were worn, was the distance spectacle prescription of either lens used of a corrective power greater than plus 8 (+8) dioptres? ☐ ☐

6. Is there a defect in his/her binocular field of vision or a history of any medical condition that may affect the applicant's binocular field of vision (central or peripheral)? If YES please provide details in section 7. ☐ ☐

7. Is there diplopia? ☐ ☐

a) If YES is it controlled? Please give full details in section 7. ☐ ☐

PLEASE TICK THE APPROPRIATE BOX(ES) ***YES*** ***NO***

8. Is there a reason to believe that there is impairment of contrast sensitivity or intolerance to glare? ☐ ☐

9. Does the applicant have any other ophthalmic condition? ☐ ☐

If **YES to 6, 7, 8 or 9** please give details in **SECTION 7** and enclose any relevant visual field charts or hospital letters.

SECTION 2 Nervous System

1. Has the applicant 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 / / Last attack / /

c) Is the patient currently on anti-epilepsy medication? ☐ ☐
If **YES**, please fill in current medication on the appropriate section on page 3 of this form.

d) If no longer treated, please give date when treatment ended / /

e) Has the patient had a brain scan? ☐ ☐
If **YES**, please state:
MRI ☐ Date / / CT ☐ Date / /

f) Has the patient had an EEG? ☐ ☐

If YES to any of above, 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 in **SECTION 7** and supply any relevant reports.

a) Stroke or TIA (please delete as appropriate) ☐ ☐

If YES please give date / / Has there been a FULL recovery? ☐ ☐

Please provide copies of any carotid artery and/or major cerebral artery imaging reports

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 or abnormality ☐ ☐
g) Chronic neurological disorders e.g. Parkinson's disease, Multiple Sclerosis ☐ ☐

SECTION 3 Diabetes Mellitus

1. Does the applicant have diabetes mellitus? ☐ ☐
If **NO,** proceed to **SECTION 4.** If **YES,** please answer the following questions.
2. Is the diabetes managed by:-

a) Insulin? ☐ ☐
If **YES**, date started on insulin / /

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?	☐	☐
	e)	Oral hypoglycaemic agents and diet? If YES, please fill in current medication on the appropriate section on page 3 of this form	☐	☐

PLEASE TICK THE APPROPRIATE BOX(ES)			***YES***	***NO***
	f)	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 from a 3rd party?	☐	☐

If YES, to any of 4 – 6 above, please give details in SECTION 7

SECTION 4 Psychiatric Illness

Is there a history of, or evidence of any of the conditions listed at 1 – 7 below? ☐ ☐

If **NO**, please go to **SECTION 5.** If **YES**, please tick the relevant box(es) below and give dates(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 on page 3.

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 dependancy in the past 3 years?	☐	☐
6.	Persistent drug misuse in the past 12 months	☐	☐
7.	Drug dependency in the past 3 years	☐	☐

SECTION 5 Cardiac

Please follow the instructions in all Sections (5a – 5G) giving details as required at SECTION 7 of the form and enclose relevant hospital notes.

5A. Coronary Artery Disease

Is there a history of, or evidence of, coronary artery disease? ☐ ☐

If **NO**, please go to **SECTION 5B.** If **YES**, please answer all questions below and give details at **SECTION 7.**

1.	Acute Coronary Syndromes including Myocardial Infarction?		☐	☐
	If **YES,** please give date(s)	/ /		
2.	Coronary artery by-pass graft surgery?		☐	☐
	If **YES,** please give date(s)	/ /		
3.	Coronary Angioplasty (P.C.I.)?	/ /	☐	☐

If **YES,** please give date(s)

4. Has the applicant suffered from Angina? ☐ ☐

If **YES**, PLEASE give date of the last known attack / /

Please proceed to next SECTION 5B

PLEASE TICK THE APPROPRIATE BOX(ES) *YES* *NO*

5B. Cardiac Arrhythmia

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 at **SECTION 7.**

1. Has the applicant had a **significant** disturbance of cardiac rhythm?
i.e. sinoatrial disease, significant atria-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the past 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 supply date of implantation / /

b) Is the patient free of symptom that caused the device to be fitted? ☐ ☐

c) Does the patient attend a pacemaker clinic regularly? ☐ ☐

Please proceed to next SECTION 5C

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

Is there history or evidence of **ANY** of the following: ☐ ☐

If **YES** please tick **ALL** relevant box(es), and give details at **SECTION 7**

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 / /

4. **DISSECTION OF THE AORTA REPARIED SUCCESSFULLY** ☐ ☐
If **YES**: please provide copies of all reports to include those dealing with any surgical treatment

Please proceed to next SECTION 5D

5D. Valvular/Congential Heart Disease

Is there a history of, or evidence, of valvular/congential heart disease? ☐ ☐
If **NO**, please go to **SECTION 5E**

If **YES**, please answer all questions below and give details at **SECTION 7.**

1.	Is there a history of congenital heart disorder?	☐	☐
2.	Is there a history of heart value disease?	☐	☐
3.	Is there any history of embolism? (not pulmonary embolism)	☐	☐
4.	Does the applicant currently have significant symptoms?	☐	☐
5.	Has there been any progression since the last licence application (if relevant)	☐	☐

Please proceed to next SECTION 5E

PLEASE TICK THE APPROPRIATE BOX(ES) ***YES*** ***NO***

5E. Cardiac Other

Does the applicant have a history of **ANY** of the following conditions:		☐	☐
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**, to any part of the above, please give full details in **SECTION 7.** If **NO**, proceed to **SECTION 5F**

This section MUST be completed for ALL patients

5F. Cardiac Investigations

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?	☐	☐
	Please provide a copy of the ECG report (if available) or comment at Section 7		
2.	Has an exercise ECG been undertaken (or planned)?	☐	☐
	If **YES,** please give date 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 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 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 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 and give details in **SECTION 7** / /		
	Please provide relevant reports if available		

Please proceed to SECTION 5G

This section MUST be completed for ALL Patients

5G. Blood Pressure

1.	Is today's best systolic pressure reading180mm Hg or more?	☐	☐

2. Is today's best diastolic pressure 100mm Hg or more? ☐ ☐

Please give today's reading / | / /

3. Is the applicant on anti-hypertensive treatment? ☐ ☐

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

/ | / / / | / / / | / /

PLEASE TICK THE APPROPRIATE BOX(ES) ***YES NO***

SECTION 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**.

1. Is there **currently** a disability of the spine or limbs which is likely to impair control of the vehicle? ☐ ☐

2. a) 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

b) Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving? ☐ ☐

3. Is the applicant 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 MINICOM/text phone? ☐ ☐

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 symdrome? ☐ ☐
If **YES**, please provide details

a) Date of diagnosis / /

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 cm

g) Date last seen by consultant / /

6. Does the patient suffer from narcolepsy or cataplexy? ☐ ☐
If **YES,** please give date and give details in **SECTION 7**

7. Is there any other **Medical Condition**, causing excessive daytime sleepiness? ☐ ☐

If **YES**, please give full details

a) Diagnosis

b) Date of diagnosis / /

c) Is it controlled successfully? ☐ ☐

d) If YES, please state treatment

e) Please state period of control

f) Date last seen by consultant / /

PLEASE TICK THE APPROPRIATE BOX(ES)		YES	NO
8.	Does the patient have severe symptomatic respiratory disease causing chronic hypoxia?	☐	☐
9.	Does any medication currently taken cause the patient side effects which could affect safe driving?	☐	☐

If **YES**, please give full details below

10.	Does the patient have any other medical condition that could affect safe driving?	☐	☐

If **YES**, please give full details below

PLEASE REMEMBER TO COMPLETE SECTION 7 IF YOU ANSWERED YES TO A QUESTION THAT REQUIRES FURTHER DETAILS.

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

SECTION 8

MEDICAL PRACTITIONER DETAILS

To be completed by Doctor carrying out the examination

Name of Doctor:

Address:

Post Code Tel.No:

Surgery Stamp or GMC Registration No.

	YES	NO
I consider that the applicant meets the criteria for Group 2 Vocational Driver's Licence as set out in the latest editions of the DVLA publication "For Medical Practitioners – at a Glance Guide for Current Medical Standards Of Fitness to Drive" and the Medical Commission on Accident Prevention's publication "Medical Aspects of Fitness to Drive".	☐	☐

Signature of Medical Practitioner : Date of Examination: