Elmbridge Borough Council
... bridging the communities ...

Environmental Services
Civic Centre, High Street
Esher, Surrey KT10 9SD
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DX: 36302 Esher
Email: envhealth@elmbridge.gov.uk
Website: www.elmbridge.gov.uk

Medical Report for an Applicant or Licensee
Hackney Carriage/Private Hire Vehicle Driver Licensing

GDPR Privacy notice

Who we are and what we do

Elmbridge Borough Council is the 'Controller' of any personal data that you provide to us. We collect, process and store your personal data in relation to your application for a licence.

What we need to process your application

In this medical report, we require you to provide personal data including your name, address, contact details and medical history.

Why we need it

We need your personal and sensitive data to enable us to process your application. If you do not provide this information we cannot process your application.

What we do with it

We will store your personal data in our licensing database and it will be accessed by authorised Council employees. We will use your personal data to enable us to monitor compliance with your licence and to carry out our enforcement duties. We may share your personal data with the other public bodies and enforcement authorities for the purposes of investigation, to protect public funds and prevent and detect fraud. We may also share your personal data with the DVLA and the Council's medical advisor.

How long we keep it

If we do not grant your licence, we will retain your data for six years from the date of the final decision on your application. If we grant your licence, we will retain your data for the period of the licence and a further six years.

What are your rights?

Please refer to our corporate privacy policy at http://www.elmbridge.gov.uk/privacy-notices/

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Please complete this form using CAPITAL LETTERS and in black ink as it will be scanned.

Notes:

1. **For the Applicant or Licensee** (Part A)

   This medical report **cannot** be issued free of charge as part of the National Health Service. You must pay the Medical Practitioner's fee, where applicable. The Council accepts no liability to pay it.

2. This report should be completed by a General Practitioner with whom you have been registered for at least **12 months** or by a General Practitioner who has access to your medical records.

3. **For the Medical Practitioner** (Part B)

   (a) When completing the medical report, please have regard to the latest version of the "Assessing fitness to drive – a guide for medical professionals", published by the DVLA, Swansea. See: https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals

   (b) Please tick the answers that apply. **If you answer 'Yes' to any of the questions on the form please give full details in the box at the end of the form.**

   (c) Please note that you may be contacted by the Council's independent medical advisor if there are any queries regarding the information supplied.

   (d) Please ensure all pages of this document are individually stamped with your surgery details on completion.

Part A: Information about the Applicant or Licensee

New applicant ☐ Current licensee ☐

1. Full name (Block Capitals) ……...

2. Address ……...

   ……..

   Postcode…… Daytime Telephone Number:……

3. Date of Birth ……(Day) ……. (Month)…….... (Year)

4. Name and Address of your present doctor or of the medical practice with which you have been registered for the last twelve months:

   ……..

   ……..

   …… Postcode……

☐ I confirm that I have read the privacy notice on the first page of this medical report form and I understand how the Council will process my personal data in respect of this medical report and my rights in respect of that data.

☐ I hereby consent to the Medical Advisor to the Licensing Authority and the Licensing Officer receiving reports from my doctors and specialists about my medical condition as required for a period of up to 12 months from the date below:

Applicant's Signature …….. Date …….....

(Please sign in the presence of the Medical Practitioner who signs the report (Part B))

Part B: Medical Report – to be completed by the Doctor

Section 1 Cardiology			Please give details and copies of relevant hospital letters if possible
		Yes / No	
a	Has the applicant had coronary by pass surgery within the last 6 months or angioplasty within the last 3 months. If yes please give details and go no further.	☐ ☐	
b	Is there evidence of congenital heart disease requiring regular Consultant cardiological review?	☐ ☐	
c	Is a cardiac pacemaker fitted?	☐ ☐	
d	Is there a history of		
	i. A single cardiac infarction?	☐ ☐	
	ii. Successful coronary artery by-pass graft (CABG) surgery more than six months ago?	☐ ☐	
	iii. Successful coronary angioplasty more than three months ago? **N.B.** a recent resting ECG is required with this report if any questions in section 1 are answered in the affirmative.	☐ ☐	
e	In respect of the NOTE above, does a resting ECG show typical Q waves of infarction? **N.B.** a relevant Q wave is defined as having an amplitude of 40 milliseconds and a depth of at least a 1/3rd of the succeeding R wave in any lead apart from AVR and V1.	☐ ☐	

		Yes	No
f	Is there evidence of left bundle branch block?	☐	☐
g	Does the applicant suffer from angina or require continuing symptomatic treatment for angina?	☐	☐
h	Is there a history of more than one cardiac infarction or coronary heart attack?	☐	☐
i	Is there persisting atrial fibrillation or a history of two episodes of cardiac arrhythmia in the past 12 months?	☐	☐
j	Is there a history of cardio-vascular aneurysm?	☐	☐
k	Has the applicant had a heart transplant?	☐	☐
l	Is there a history of peripheral arterial disease leading to sickness absence from work, or associated with cardiac infarction?	☐	☐
m	Is the established systolic blood pressure 200 or over, or is the established diastolic blood pressure 110 or over?	☐	☐
n	Is the established systolic blood pressure 170 or over, or is the established diastolic blood pressure 95 or over?	☐	☐
o	Is hypotensive medication prescribed? If yes please include details at Section 9.	☐	☐
p	If "Yes" does it give rise to giddiness or fainting?	☐	☐
q	Is there a history of heart valve surgery or heart disease requiring anti-coagulant medication?	☐	☐
r	Is there a history of X-ray evidence of heart enlargement?	☐	☐
	If "Yes" is the cardiothoracic ratio 0.55 or over? Attach copies of reports if possible	☐	☐

Section 2 Diabetes Mellitus

		Yes	No
a	Is the applicant diabetic? If "Yes" please answer **b** and **c**	☐	☐
b	Is insulin treatment required?	☐	☐
c	Is there evidence of diabetic retinopathy laser treatment, or severe peripheral neuropathy?	☐	☐
d	When treated with medication other than insulin which carries a risk of inducing hypoglycaemia (including sulphonylureas and glinides) the following standards must be reached:		
	• there have not been any severe hypoglycaemic events in the last 12 months	☐	☐
	• the driver has full hypoglycaemic awareness	☐	☐
	• the driver has adequate control of the condition by regular blood glucose monitoring, at least twice daily and at times relevant to driving	☐	☐
	• the driver must demonstrate an understanding of the risks of hypoglycaemia	☐	☐
	• there are no other debarring complications of diabetes	☐	☐

Section 3 Nervous System

		Yes	No
a	Has the applicant suffered an epileptic attack since attaining the age of 5 years?	☐	☐
b	Is there a history of blackout(s) or recurring episodes of altered consciousness other than simple syncope?	☐	☐
c	Is there a history of transient ischaema, amaurosis fugax or stroke?	☐	☐
d	Is there a history of recurring Ménières disease or vertebro-basilar artery insufficiency in the past 2 years?	☐	☐
e	Is there a history of Multiple Sclerosis or Parkinsonism?	☐	☐
f	Is there a history of major brain surgery (other than to the posterior fossa?)	☐	☐
g	Is there a history of head injury with evidence of an intra-cerebral haematoma, early epilepsy or compound depressed skull fracture?	☐	☐
h	Is there profound deafness that prevents communication by telephone?	☐	☐

Section 4 Psychiatric Illness

		Yes	No
a	Has the applicant suffered a psychotic illness or required treatment for a psychotic illness in the past 5 years?	☐	☐
b	Has the applicant suffered from a mental disorder requiring treatment with psychotropic medication within the last 6 months?	☐	☐
c	Is there a history of dementia?	☐	☐
d	Is there any history of alcohol abuse in the last 5 years?	☐	☐
e	Is there any history of drug or substance abuse in the last 5 years?	☐	☐

Section 5 Vision

Note: Visual acuities must be measured by Snellen Chart.
If in doubt, please refer to local optician for assessment.

		Yes	No
a	Is the visual acuity with or without the use of corrective lenses worse than 6/9 in one eye, and 6/12 in the other eye?	☐	☐

i. If "Yes", please state the acuities without lenses: ii. Acuities corrected by lenses:

Left ☐ Right ☐ Left ☐ Right ☐

b	Is the uncorrected visual acuity (i.e. without the use of spectacles or contact lenses) worse than 3/60 in either eye – equivalent to reading 6/60 line at 3 metres?	☐	☐
c	Is the applicant without sight in one eye?	☐	☐
d	Is there diplopia or evidence of a pathological field defect – e.g. hemianopia?	☐	☐

Section 6 Malignant Growths

		Yes	No
a	Is there a history of any malignancy in the last 5 years? If YES please give details.	☐	☐
b	Specifically is there a history of a malignant brain lesion?	☐	☐

Section 7 Musculoskeletal System

	Yes	No
Has the applicant any deformity, loss of limbs or parts of limbs, or physical disability (with special attention paid to the condition of the arms, legs, hands and joints) which is likely to interfere with the efficient discharge of his/her duties as a vocational driver?	☐	☐

Section 8 Other Conditions

	Yes	No
Does the applicant suffer from any medical condition not mentioned above, which is likely to interfere with the discharge of his/her duties as a driver?	☐	☐

If "Yes", please specify the condition(s) and give details.

Section 9 Medication

Please give details of all current regular medication. Continue on an attached sheet if necessary. Only one entry is needed for each medication**.**
Alternatively please attach a copy of a repeat prescription form.

Date prescribed	Medication	Dose e.g. 300 mg three times a day	If this is ongoing medication how long has it been prescribed for?

Further details:

I certify that I have this day examined the applicant, whose medical records for the last 12 months I have had full access to, who has signed this form (Part A) in my presence and I further certify that information that I have given on this form is true and correct.

Signed …… Name ……
(Registered Medical Practitioner (Block Capitals)

GMC Ref. No:…….. Date: ……

Address ……

……

……. Telephone……..