







**1 Neurological disorders**

Please tick ✓ the appropriate boxes  
Is there 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 and enclose relevant hospital notes.

1. Has the applicant had any form of seizure? Yes No  
   
(a) Has the applicant had more than one seizure episode?    
(b) If Yes, please give date of first and last episode.  
First episode          
Last episode          
(c) Is the applicant currently on anti-epileptic medication?    
If Yes, please fill in the medication section 8, page 6.  
(d) If no longer treated, when did treatment end?          
(e) Has the applicant had a brain scan?    
If Yes, please give details in section 9, page 7.  
(f) Has the applicant had an EEG?    
If you have answered Yes to any of above, you must supply medical reports.
2. Has the applicant experienced dissociative/'non-epileptic' seizures? Yes No  
   
(a) If Yes, please give date of most recent episode.          
(b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?
3. Stroke or TIA? Yes No  
If Yes, give date.          
(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 10 years?

**2 Diabetes mellitus**

Does the applicant have diabetes mellitus? Yes No

**If No, go to section 3, Cardiac**

If Yes, please answer all questions below.

1. Is the diabetes managed by: Yes No  
(a) Insulin?    
If No, go to 1c  
If Yes, please give date started on insulin.          
(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 7.  
(c) Other injectable treatments?    
(d) A Sulphonylurea or a Glinide?    
(e) Oral hypoglycaemic agents and diet?    
If Yes to any of (a) to (e), please fill in the medication section 8, page 6.  
(f) Diet only?
2. (a) Does the applicant test blood glucose at least twice every day? Yes No  
   
(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? Yes No  
   
(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? Yes No  
   
If Yes, please give details and dates below.
5. Is there evidence of: Yes No  
(a) Loss of visual field?    
(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?    
If Yes, please give details in section 9, page 7.
6. Has there been laser treatment or intra-vitreous treatment for retinopathy? Yes No  
   
If Yes, please give most recent date of treatment.

Applicant's full name

Date of birth



### 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 and enclose relevant hospital notes.

1. Has the applicant ever had an episode of angina? Yes No

If Yes, please give the date of the last known attack.

2. Acute coronary syndrome including myocardial infarction? Yes No

If Yes, please give date.

3. Coronary angioplasty (PCI)? Yes No

If Yes, please give date of most recent intervention.

4. Coronary artery bypass graft surgery? Yes No

If Yes, please give date.

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 and enclose relevant hospital notes.

1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) 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.

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

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

Applicant's full name

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Date of birth

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#### 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 and enclose relevant hospital notes.

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

4. Dissection of the aorta repaired successfully? Yes No  
 If Yes, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? Yes No  
 If Yes, please provide relevant hospital notes.

#### 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, answer all questions below and provide relevant hospital notes.

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

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

3. Is there a history of aortic stenosis? Yes No  
 If Yes, please provide relevant reports (including echocardiogram).

4. Is there history of embolic stroke? Yes No

5. Does the applicant currently have significant symptoms? Yes No

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





## 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 7, Further details.

- b) Please answer questions (i) to (vi) for **all** sleep conditions.

(i) Date of diagnosis:       Yes  No

(ii) Is it controlled successfully?  Yes  No

(iii) If Yes, please state treatment.

(iv) Is applicant compliant with treatment? Yes  No

(v) Please state period of control:

years  months

(vi) Date of last review.

## 7 Other medical conditions

1. Is there a history or evidence of narcolepsy? Yes  No

2. Is there currently any functional impairment that is likely to affect control of the vehicle? Yes  No

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? Yes  No

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? Yes  No

5. Is the applicant profoundly deaf? Yes  No

If Yes, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone? Yes  No

6. Does the applicant have a history of liver disease of any origin? Yes  No

If Yes, is this the result of alcohol misuse?  Yes  No

If Yes, please give details in section 9, page 7.

7. Is there a history of renal failure? Yes  No

If Yes, please give details in section 9, page 7.

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes  No

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? Yes  No

If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.

10. Does the applicant have any other medical condition that could affect safe driving? Yes  No

If Yes, please provide details in section 9, page 7.

## 8 Medication

Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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Reason for taking:	
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Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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## 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 investigation into your fitness to drive, we (DVLA) may require 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](http://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 (fax and/or 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.**