



TPH/204

Medical Declaration

Transport for London (TfL), the Licensing Authority, needs to be satisfied that all licensed London Taxi and Private Hire drivers are medically fit. In assessing an individuals medical fitness, TfL has decided to be guided by the DVLA Group 2 standards.

This form should be taken to a registered medical practitioner who has access to your full medical history, typically your GP, for completion. If it is not completed by someone who has access to your full medical history this could lead to delays in the processing of your medical.

This medical report is for the confidential use of TfL.

This medical report **cannot** be issued free of charge as part of the National Health Service. The applicant must pay the medical practitioners fee, unless other arrangements have been made. TfL accepts no liability to pay it.

If you possess a valid DVLA Group 2 licence or are already licensed by TfL as either a MHC ('taxi') or PHV driver and are now applying for the other licence, you do not need to have this form completed, unless this form has been requested in regards to confirming your age related fitness.

When completing this application please:

- Write inside the boxes - use BLOCK CAPITAL letters and black ink
- If you make a mistake, please cross it out (initial it) and write the correct information underneath
- Do not use correction fluid - Ensure that a response is provided for **every** question, unless specifically directed to the contrary.

On completion, this form should be returned to:

TfL London Taxi & Private Hire
PO Box 177
Sheffield
S98 1JY

Further information may be requested from you should it be required in order to determine your medical fitness.

TfL recommends that all individuals take a photocopy of this form once it is completed for their own record before submitting the original.

A - Personal Details**A1 Surname**

A2 Forenames(s)

A3 Date of Birth

A4 Current address**Postcode**

Rest of address

B - Registered GP Details**B1 Name or Registered GP**

B2 Address**Postcode****Premises number**

Rest of address

C - Applicant/Driver Consent and Declaration**Data Protection**

Transport for London (TfL) and its agents will use the information that you have provided on this form and subsequent information provided by you or others for the purpose of assessing your application to hold a Taxi or PHV Driver licence and for the administration of the licensing regime. If your application is successful your name, licence number, licence status, issue date and expiry date will be made available on a public register. By signing this form you are consenting to the processing of your data by TfL for these purposes. Your information may be passed to law enforcement agencies if criminal activity is suspected or where we are otherwise required to do so by law.

Consent and Declaration

I here by consent to Transport for London (TfL) and their medical advisers processing personal data relating to my medical conditions for the purpose of assessing my fitness to hold a Taxi or PHV Driver licence. I also give consent for my doctors and specialists to provide TfL with any data they require in relation to this application.

Signature**Date**

TfL recommends that all individuals take a photocopy of this form once it is completed for their own record before submitting the original.

D - Medical Conditions - to be completed by GP

Sections D - F must be completed by the applicants/drivers registered GP (detailed in section B) who should:

- Have access to the applicants full medical history
- Answer all the relevant questions
- Consult the DVLA's publication 'At a Glance Guide to the Current Medical Standards of Fitness to Drive.'

http://www.dvla.gov.uk/at_a_glance/what_is.htm

Regulations state that Taxi and PHV drivers must satisfy TfL that they are medically fit to hold a driver's licence. In assessing whether an applicant is medically fit, TfL will have regard to the medical standard that would apply in relation to a DVLA Group 2 licence.

If you answer 'Yes' to ANY of the questions on this medical form, you must consult the DVLA's publication 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' and provide ALL the relevant information required for the condition(s) in accordance with the requirements of a Group 2 licence entitlement.

1 Cardiovascular disease/procedure

Does the applicant have a history of:

(a) Acute Coronary Syndrome including Myocardial infarction

Yes	No
<input type="text"/>	<input type="text"/>

If 'Yes', please provide date(s):

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(b) Coronary artery by-pass graft (CABG)

<input type="text"/>	<input type="text"/>
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If 'Yes', please provide date(s):

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(c) Percutaneous Coronary Intervention (P.C.I.) (Angioplasty)

<input type="text"/>	<input type="text"/>
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If 'Yes', please give date of most recent intervention:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(d) Angina

<input type="text"/>	<input type="text"/>
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If 'Yes', please give date of the last know attack:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(e) Heart failure

<input type="text"/>	<input type="text"/>
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(f) Implantable Cardioverter Defibrillator (ICD)

<input type="text"/>	<input type="text"/>
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(g) Cardiac Pacemaker

<input type="text"/>	<input type="text"/>
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(h) Any other coronary artery disease/procedure

<input type="text"/>	<input type="text"/>
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If you answer 'Yes' to any of the above, please provide further details in section E (on page 8) and submit any relevant reports.

2 Other Cardiovascular disease/procedure

Does the applicant have a history of:

(a) Cardiac arrhythmia

Yes	No
<input type="text"/>	<input type="text"/>

If 'Yes', when was the last recorded occurrence?
AND complete question 3(c)

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

(b) Peripheral arterial disease

<input type="text"/>	<input type="text"/>
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If you answer 'Yes' to any of the above, please provide further details in section E (on page 8) and submit any relevant reports.

2 Other Cardiovascular disease/procedure

Does the applicant have a history of:

	Yes	No
(c) Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes'. please provide the following:		
(i) Site of aneurysm Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/>		
(ii) Has it been successfully repaired?	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Please provide size of aortic diameter..... and date obtained:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
(d) Dissection of the aorta	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes'. please provide copies of all reports to include those dealing with any surgical treatment		
(e) Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
(f) Systolic reading consistently above 180/diastolic reading consistently above 100	<input type="checkbox"/>	<input type="checkbox"/>
(g) Please provide a current blood pressure reading		
(h) Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes'. please state which type: AND provide full details in section E (on page 8)		
(i) Congenital heart disorders	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Any other cardiac condition(s) not listed above	<input type="checkbox"/>	<input type="checkbox"/>

If you answer 'Yes' to any of the above, please provide further details in section E (on page 8) and submit any relevant reports.

3 Cardiac investigations

	Yes	No
(a) Has the applicant undergone an exercise ECG test	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes'. please give date and provide full details in section E (on page 8):		
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
(b) Has the applicant undergone a myocardial perfusion scan or stress echo study	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes'. please give date and provide full details in section E (on page 8):		
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
(c) Has the applicant had an LVEF reading taken?	<input type="checkbox"/>	<input type="checkbox"/>
Please provide the reading (e.g. 40% or 0.4):		
	<input type="text"/>	
Please provide the date reading was taken AND provide full details in section E (on page 8)		
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

4 Musculoskeletal

	Yes	No
(a) Does the applicant have any deformity or physical disability (with special attention paid to the conditions of the arms, legs, hands and joints)	<input type="checkbox"/>	<input type="checkbox"/>
(b) Is this likely to interfere with efficient discharge of his or her duties as a vocational driver	<input type="checkbox"/>	<input type="checkbox"/>

If you answer 'Yes' to any of the above, please provide further details in section E (on page 8) and submit any relevant reports.

5 Diabetes Mellitus

	Yes	No								
(a) Does the applicant have diabetes mellitus?	<input type="checkbox"/>	<input type="checkbox"/>								
If 'No', please continue to question 6										
If 'Yes', is it managed by:										
(i) Diet alone	<input type="checkbox"/>	<input type="checkbox"/>								
(ii) Oral hypoglycaemic agents not likely to cause hypoglycaemia (including metformin)	<input type="checkbox"/>	<input type="checkbox"/>								
(iii) Oral hypoglycaemic agents with potential to cause hypoglycaemia including gliptins, sulphonyurea, glinides, exenatide, and/or others	<input type="checkbox"/>	<input type="checkbox"/>								
If 'Yes' please give date started on agents and complete ALL of question (b) below		<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
(iv) Insulin	<input type="checkbox"/>	<input type="checkbox"/>								
If 'Yes' please give date started insulin and complete ALL of question (b) below		<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
(b) Diabetic history										
(i) During the past 12 months prior to the date of the licence application, has the applicant suffered a hypoglycaemic episode requiring the assistance of another at any time (If 'Yes' please provide further details below)	Yes <input type="checkbox"/>	No <input type="checkbox"/>								
(ii) Does the applicant have a history of responsible diabetic control (If 'No' please provide further details below)	No <input type="checkbox"/>	Yes <input type="checkbox"/>								
(iii) Does the applicant have good hypoglycaemic awareness (If 'No' please provide further details below)	No <input type="checkbox"/>	Yes <input type="checkbox"/>								
(iv) As far as you know, is the applicant adherent to treatment protocols, twice daily blood sugars measurements and at times relevant to driving (If 'No' please provide further details below)	No <input type="checkbox"/>	Yes <input type="checkbox"/>								
(v) Is the applicant at minimal risk (i.e. Low risk) of hypoglycaemic attack resulting in incapacity (If 'No' please provide further details below)	No <input type="checkbox"/>	Yes <input type="checkbox"/>								
(vi) Does the applicant have any complications of diabetes which may interfere with driving (If 'No' please provide further details below)	Yes <input type="checkbox"/>	No <input type="checkbox"/>								

Diabetes Mellitus further information

6 Neurological

Does the applicant have a history of:

	Yes	No
(a) Seizure/Epileptic attack and/or having taken anti-convulsant/epileptic medication in the last 10 years	<input type="checkbox"/>	<input type="checkbox"/>
(b) A first unprovoked epileptic seizure/solitary fit within the last 5 years	<input type="checkbox"/>	<input type="checkbox"/>
(c) Blackout/Impairment of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
(d) Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes', please give the date and complete ALL the questions below:		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
(i) Has there been a full recovery?	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Is there any debarring residual impairment that would affect safe driving?	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Any other significant risk factors?	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Is there any imaging evidence of less than 50% carotid artery stenosis?	<input type="checkbox"/>	<input type="checkbox"/>
(l) Has exercise/functional testing been undertaken? If 'Yes', please ensure you complete question 3 of this form (on page 4)	<input type="checkbox"/>	<input type="checkbox"/>
(e) Sudden Disabling Dizziness/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
(f) Pathological Sleep Disorder	<input type="checkbox"/>	<input type="checkbox"/>
(g) Chronic and/or Progressive Neurological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
(h) Brain Surgery	<input type="checkbox"/>	<input type="checkbox"/>
(i) Traumatic Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>
(j) Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>

If you answer 'Yes' to any of the above, please provide further details in section **E** (on page 8) and submit any relevant reports.

7 Psychiatric

Does the applicant have a history of:

	Yes	No
(a) Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>
(b) Psychotic Illness	<input type="checkbox"/>	<input type="checkbox"/>
(c) Dementia/Cognitive Impairment	<input type="checkbox"/>	<input type="checkbox"/>
(d) Alcohol Misuse	<input type="checkbox"/>	<input type="checkbox"/>
(e) Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>
(f) Drug or Substance Misuse	<input type="checkbox"/>	<input type="checkbox"/>
(ag) Drug or Substance Dependency	<input type="checkbox"/>	<input type="checkbox"/>

If you answer 'Yes' to any of the above, please provide further details in section **E** (on page 8) and submit any relevant reports.

8 Vision

DVLA Group 2 standards require an applicant's visual acuity to be **AT LEAST** 6/7.5 (Snellen decimal 0.8) in the better eye and **AT LEAST** 6/60 (Snellen decimal 0.1) in the other (6/7.5 and 6/60 being the ability to read at least the 7.5 line and the full 60 line of the Snellen chart at 6 metres).

Where corrective lenses are worn to meet the minimum standards, they should have a corrective power of $\leq + 8$ dioptres.

If you do not have the equipment to carry out the required tests or fully complete this section, including providing the prescription measures, please refer the applicant to an Ophthalmic Specialist or Optician.

- (a) Please confirm the applicants visual acuity readings and prescription measurements (If corrective lenses for distance vision are used) in the format above.

	Corrected Visual Acuity	Uncorrected Visual Acuity	Prescription
Left	<input type="text"/>	<input type="text"/>	<input type="text"/>
Right	<input type="text"/>	<input type="text"/>	<input type="text"/>

In addition, where corrective lenses are worn, the visual acuity (with the aid of glasses or contact lenses) must be **AT LEAST** 6/12 (Snellen decimal 0.5) with both eyes open. Complete loss of vision in one eye is a bar to licensing.

Please provide binocular vision reading in the format "6/12":

Binocular Vision

(b) Does the applicant use corrective lenses for distance vision?	Yes <input type="text"/>	No <input type="text"/>
(c) Does the applicant have a normal binocular field of vision?	Yes <input type="text"/>	No <input type="text"/>
(d) Does the applicant have uncontrolled diplopia?	Yes <input type="text"/>	No <input type="text"/>
(e) Does the applicant have any other ophthalmic condition?	Yes <input type="text"/>	No <input type="text"/>

If 'Yes', please provide further details in section E (on page 8) and submit any relevant reports.

9 Any other conditions

(a) Does the applicant named in section A suffer from any recognised medical condition (such as severe asthma, allergic reaction or chronic phobia) that would preclude them from carrying Guide and/or Assistance dogs?	Yes <input type="text"/>	No <input type="text"/>
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If YES, please request form TPH/208, which must be completed by a Specialist in the field that you require exemption.

(b) (i) Does the applicant suffer from any other disease or disability that has not been previously mentioned?	Yes <input type="text"/>	No <input type="text"/>
(ii) Is this likely to interfere with the efficient discharge of his or her duties as a vocational driver, or to cause driving by him or her to be a source of danger to the public?	Yes <input type="text"/>	No <input type="text"/>

If you answer "Yes" to any of the above, please provide further details in section E (on page 8) and submit any relevant reports

E - Further Details

Please use the space below to provide further, legible details required with reference to any of the previously answered questions. Please include relevant dates. It will be necessary to consult the DVLA's publication 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' and provide information as per Group 2 standards of fitness. http://www.dvla.gov.uk/at_a_glance/what_is.htm

[Large empty text area for providing further details]

F - Declaration - to be completed by GP

At the time of examination and completion of this medical form, I had possession of the applicant's complete medical history.
Yes No

Where 'No', please state your reason(s) why:

Signature

Date

Name (BLOCK CAPITALS)

Surgery Stamp