



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

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. The visual 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 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 Yes ☐ No ☐

- (b) Are corrective lenses worn for driving? ☐ Yes ☐ No

If no, go to Q3.

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. Are 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:

If formal visual field testing is considered necessary, DVLA will commission this at a later date.

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 ☐

If yes, please give full details in Q8 below.

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 examination and the applicant's history has been taken into consideration.

Signature of examining doctor, optician or optometrist

Date of signature

D	D	M	M	Y	Y
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Please provide your GOC or GMC number

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Doctor, optometrist or optician's stamp

Applicant's full name

Date of birth

D	D	M	M	Y	Y
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Please do not detach this page



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? ☐

(b) Please give date of first and last episode.

First episode

Last episode

(c) Is the applicant currently on anti-seizure medication? ☐

(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 6.

2. Has the applicant experienced any dissociative/functional 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 5 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 treated by: Yes ☐ No ☐

(a) Insulin? ☐

If no, go to 1c

If yes, please give date started on insulin.

(b) Are there at least 4 continuous weeks of glucose readings stored on a memory meter or meters? ☐

If no, please give details in section 9, page 6.

(c) Other injectable treatments? ☐

(d) A Sulphonylurea or a Glinide? ☐

(e) Oral hypoglycaemic agents and diet? ☐

(f) Diet only? ☐

2. (a) Does the applicant monitor their glucose level using continuous glucose monitoring (CGM)? Yes ☐ No ☐

(b) If yes, is the continuous glucose monitoring (CGM) device approved for non-adjunctive use? ☐

(c) Does the applicant carry a finger prick monitoring device? ☐

(d) Does the applicant test glucose at least twice every day? ☐

(e) Does the applicant test glucose at times relevant to driving? (Within 2 hours of starting their first journey of the day and continuing to check at least every 2 hours during their journey. There must be no more than 2 hours between glucose checks at any time during their journey). ☐

(f) Does the applicant keep fast-acting carbohydrate within easy reach whilst driving? ☐

(g) 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) 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. 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

e Cardiac other	
Is there a history or evidence of heart failure?	Yes No
If no, go to section 3f, Cardiac 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 6.	☐ ☐
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	Yes No
	☐ ☐
4. A heart or heart/lung transplant?	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 6.	☐	☐

g Blood pressure

All questions must be answered.

If resting blood pressure is 180 mm/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 readings in the box provided.

1. Please record today's best resting blood pressure reading.

2. Is the applicant on anti-hypertensive treatment? Yes No
If yes, please provide three previous readings with dates if available.

	/								
	/								
	/								

D	D	M	M	Y	Y
D	D	M	M	Y	Y
D	D	M	M	Y	Y

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) or (c), please give details in section 9, page 6.	
Note: If yes to questions 2 to 5, please give dates in the boxes provided, give details in section 9, page 6.	
2. Has an exercise ECG been undertaken (or planned)?	Yes No
	DDMMYY

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 ☐

(a) If yes, the type of substance misused?

(b) Is it controlled? ☐ ☐

(c) Has the applicant undertaken an opiate treatment programme? ☐ ☐

If yes, give date started

D	D	M	M	Y	Y
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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 6, Further details.

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

(i) Date of diagnosis: Yes ☐ No ☐

(ii) Is it controlled successfully? ☐ ☐

(iii) Is applicant compliant with treatment? ☐ ☐

(iv) Date of last review.

7 Other medical conditions

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

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? Yes ☐ No ☐

If yes, please provide information in section 9, page 6.

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

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

If yes, is this the result of alcohol misuse? ☐ ☐

If yes, please give details in section 9, page 6.

5. Is there a history of renal failure? Yes ☐ No ☐

If yes, please give details in section 9, page 6.

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

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

If yes, please provide details in section 9, page 6.

8 Medication

Is the applicant currently prescribed any of the following medication:

(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 full name

Date of birth

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:	DDMMYY
Consultant in	
Reason for attendance	
Name	
Address	
Date of last appointment:	DDMMYY
If more consultants seen give details on a separate sheet.	

11 Examining doctor's signature and stamp	
To be filled in by the doctor carrying out the examination.	
Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this.	
I confirm that this report was filled in by me at examination and I have taken the applicant's history into account. I also confirm that I am currently GMC registered and licensed to practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK.	
Signature of examining doctor	
Date of signature	DDMMYY
Doctor's stamp	

[illegible]

D	D	M	M	Y	Y
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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 enquiries into your fitness to drive, we (DVLA) may need 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

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 (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.