Medical examination report for a Group 2 (lorry or bus) licence

If this form is not fully completed it will be returned and the application will be delayed.

For information about completing the form read the leaflet INF4D. This can also be viewed in PDF format at www.gov.uk/reapply-driving-licence-medical-condition

All black outlined boxes must be answered

Pages 1 and 8 must be completed by the applicant

Your name

Address & postcode

Date of birth

Daytime contact phone number

Email address

Date first licenced to drive a lorry (if known)

Date first licenced to drive a bus (if known)

Your doctor’s details

Name of doctor

Address & postcode

Phone number

Email (if known)

You must sign and date the declaration on page 8 when the doctor and/or optician has completed the report.
1. Please confirm (✓) the scale you are using to express the driver’s visual acuities.
   Snellen □ Snellen expressed as a decimal □ LogMAR □

2. Please state the visual acuity of 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.

   Uncorrected  Corrected
   (using prescription worn for driving)
   R L R L

3. Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye (corrective lenses may be worn to meet this standard)?
   YES □ NO □

4. Were corrective lenses worn to meet this standard?
   YES □ NO □
   If YES, glasses □ contact lenses □ both together □

5. If glasses (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?
   YES □ NO □

6. If correction is worn for driving, is it well tolerated?
   YES □ NO □
   If NO, please give full details in the box provided □

   If you answer yes to any of the following give details in the box provided.

7. Is there a history of any medical condition that may affect the applicant’s binocular field of vision (central and/or peripheral)?
   YES □ NO □
   If formal visual field testing is considered necessary, DVLA will commission this at a later date □

8. Is there diplopia?
   YES □ NO □
   (a) If YES, is it controlled?
   If YES, please give full details in the box provided □

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision?
   YES □ NO □

10. Does the applicant have any other ophthalmic condition?
    YES □ NO □
    If YES, please give full details in the box provided □

You must sign and date this section.
Name of examining doctor/optician (print)
                                                                                           □

Signature of examining doctor/optician                                                                                           □
                                                                                           □

Date of signature D M Y Y                                                                                           □

Please provide your GOC, HPC or GMC number                                                                                           □

Doctor/optometrist/optician's stamp                                                                                           □

Applicant’s full name                                                                                           □

Date of birth D M Y Y                                                                                           □

Please do not detach this page
### Medical examination report

**Medical assessment**

Must be filled in by a doctor

- Please check the applicant’s identity before you proceed.
- Please ensure you fully examine the applicant as well as taking the applicant's history.

#### 1 Nervous system

Please tick ✓ the appropriate box(es)

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<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Is there a history of, or evidence of any neurological disorder?</td>
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<td>If NO, go to section 2</td>
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<tr>
<td>If YES, please answer ALL questions below</td>
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<tr>
<td>1. Has the applicant had any form of seizure?</td>
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<tr>
<td>(a) Has the applicant had more than one attack?</td>
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<tr>
<td>(b) Please give date of first and last attack</td>
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<tr>
<td>First attack: D D M M Y Y</td>
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<tr>
<td>Last attack: D D M M Y Y</td>
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<tr>
<td>(c) Is the applicant currently on anti-epileptic medication?</td>
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<td>If YES, please fill in current medication in section 8, page 7</td>
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<td>(d) If no longer treated, please give date when treatment ended D D M M Y Y</td>
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<tr>
<td>(e) Has the applicant had a brain scan?</td>
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<td>If YES, please give details in section 6, page 6</td>
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<td>(f) Has the applicant had an EEG?</td>
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<td>If YES to any of above, please supply reports if available.</td>
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<th>YES</th>
<th>NO</th>
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<td>Is there ANY history of the following:</td>
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<td>2. Stroke or TIA?</td>
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<td>If YES, please give date D D M M Y Y</td>
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<td>Has there been a FULL recovery?</td>
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<td>Has a carotid ultra sound been undertaken?</td>
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<td>3. Sudden and disabling dizziness/vertigo within the last year with a liability to recur?</td>
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<td>4. Subarachnoid haemorrhage?</td>
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<td>5. Serious traumatic brain injury within the last 10 years?</td>
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<td>6. Any form of brain tumour?</td>
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<td>7. Other brain surgery or abnormality?</td>
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<td>8. Chronic neurological disorders?</td>
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<td>9. Parkinson's disease?</td>
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<td>10. Is there a history of blackout or impaired consciousness within the last 5 years?</td>
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<td>If YES, please give date(s) and details in section 6, page 6</td>
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<tr>
<td>11. Does the applicant suffer from narcolepsy?</td>
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<td>If YES, please give date(s) and details in section 6, page 6</td>
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#### 2 Diabetes mellitus

<table>
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<th>YES</th>
<th>NO</th>
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<td>Does the applicant have diabetes mellitus?</td>
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<td>If NO, go to section 3, page 4</td>
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<td>If YES, please answer ALL the following questions.</td>
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<td>1. Is the diabetes managed by:</td>
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<tr>
<td>(a) Insulin?</td>
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<td>If YES, please give date started on insulin D D M M Y Y</td>
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<tr>
<td>(b) If treated with insulin, are there at least 3 months of blood glucose readings stored on a memory meter(s)?</td>
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<tr>
<td>If NO, please give details in section 6, page 6</td>
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<td>(c) Other injectable treatments?</td>
<td></td>
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<tr>
<td>(d) A Sulphonylurea or a Glinide?</td>
<td></td>
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<tr>
<td>(e) Oral hypoglycaemic agents and diet?</td>
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<tr>
<td>If YES to any of a-e, please fill in current medication in section 8, page 7</td>
<td></td>
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<tr>
<td>(f) Diet only?</td>
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<tr>
<td>2. (a) Does the applicant test blood glucose at least twice every day?</td>
<td></td>
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<tr>
<td>If NO, please give details in section 6, page 6</td>
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<tr>
<td>(b) Does the applicant test at times relevant to driving?</td>
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<td>(c) Does the applicant keep fast acting carbohydrate within easy reach when driving?</td>
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<tr>
<td>(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?</td>
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<tr>
<td>3. Is there any evidence of impaired awareness of hypoglycaemia?</td>
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<tr>
<td>4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person?</td>
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<td>5. Is there evidence of:</td>
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<tr>
<td>(a) Loss of visual field?</td>
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<tr>
<td>(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?</td>
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<tr>
<td>If YES to any of 4-6 above, please give details in section 6, page 6</td>
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<tr>
<td>6. Has there been laser treatment or intra-vitreal treatment for retinopathy?</td>
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<tr>
<td>If YES, please give date(s) of treatment.</td>
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</table>

|Applicant's full name | Date of birth D D M M Y Y |

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D4
3 Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years? [ ] [ ]

If NO, go to section 4

If YES, please answer ALL questions below

1. Significant psychiatric disorder within the past 6 months? [ ] [ ]

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? [ ] [ ]

3. Dementia or cognitive impairment? [ ] [ ]

4. Persistent alcohol misuse in the past 12 months? [ ] [ ]

5. Alcohol dependence in the past 3 years? [ ] [ ]

6. Persistent drug misuse in the past 12 months? [ ] [ ]

7. Drug dependence in the past 3 years

If ‘YES’ to any questions above, please provide full details in section 6, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

4 Cardiac

a Coronary artery disease

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

If NO, go to section 4b

If YES, please answer ALL questions below and give details at section 6 of the form and enclose relevant hospital notes.

1. Has the applicant suffered from angina?
   If YES, please give the date of the last known attack
   [ ] [ ]

2. Acute coronary syndrome including myocardial infarction?
   If YES, please give date
   [ ] [ ]

3. Coronary angioplasty (P.C.I.)?
   If YES, please give date
   [ ] [ ]

4. Coronary artery by-pass graft surgery?
   If YES, please give date
   [ ] [ ]

b Cardiac arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? [ ] [ ]

If NO, go to section 4c

If YES, please answer ALL questions below and give details in section 6, page 6.

1. Has there been a significant disturbance of cardiac rhythm? i.e. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in the last 5 years
   [ ] [ ]

2. Has the arrhythmia been controlled satisfactorily for at least 3 months?
   [ ] [ ]

3. Has an ICD or biventricular pacemaker (CRT-D type) been implanted?
   [ ] [ ]

4. Has a pacemaker been implanted?
   If YES:
   (a) Please supply 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?
      [ ] [ ]

Peripheral arterial disease (excluding Buerger's disease)

aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger’s disease), aortic aneurysm/dissection?

If NO, go to section 4d

If YES, please answer ALL questions below and give details in section 6 page 6, enclosing relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger’s disease)
   [ ] [ ]

2. Does the applicant have claudication?
   If YES, how long in minutes can the applicant 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 > 5.5 cm?
      [ ] [ ]
   If NO, please provide latest measurement and date obtained

4. Dissection of the aorta repaired successfully?
   If YES, please provide copies of all reports to include those dealing with any surgical treatment.

5. Is there a history of Marfan’s disease?
   If YES, please provide relevant hospital notes

Applicant’s full name [ ] Date of birth D D M M Y Y
Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease? YES NO
If NO, go to section 4e
If YES, please answer ALL questions below and give details in section 6 page 6.

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
4. Is there any history of embolism? (not pulmonary embolism) YES NO
5. Does the applicant currently have significant symptoms? YES NO
6. Has there been any progression since the last licence application? (if relevant) YES NO

Cardiac other

Is there a history of, or evidence of, heart failure? YES NO
If NO, go to section 4f
If YES, please answer ALL questions below

1. Established cardiomyopathy? YES NO
2. Has a left ventricular assist device (LVAD) been implanted? YES NO
3. A heart or heart/lung transplant? YES NO
4. Untreated atrial myxoma? YES NO

Cardiac investigations

Have any cardiac investigations been undertaken or planned? YES NO
If NO, go to section 4g
If YES, please answer ALL questions

1. Has a resting ECG been undertaken? YES NO
   - If YES, please provide relevant reports
      - (a) pathological Q waves?
      - (b) left bundle branch block?
      - (c) right bundle branch block?
   If yes to a, b or c please provide a copy of the relevant ECG report or comment at section 6, page 6.

2. Has an exercise ECG been undertaken (or planned)? YES NO
   - If YES, please give date and give details in section 6, page 6
   - Please provide relevant reports if available

3. Has an echocardiogram been undertaken (or planned)? YES NO
   - (a) If YES, please give date and give details in section 6, page 6
   - Please provide relevant reports if available

4. Has a coronary angiogram been undertaken (or planned)? YES NO
   - If YES, please give date and give details in section 6, page 6
   - Please provide relevant reports if available

5. Has a 24 hour ECG tape been undertaken (or planned)? YES NO
   - If YES, please give date and give details in section 6, page 6
   - Please provide relevant reports if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)? YES NO
   - If YES, please give date and give details in section 6, page 6
   - Please provide relevant reports if available

Blood pressure

If blood pressure is 180/100mm 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 blood pressure reading YES NO

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

Applicant’s full name

Date of birth DD MM YYYY
5 General

All questions MUST be answered
If YES to any, give full details in section 6,

1. Is there currently any functional impairment that is likely to affect control of the vehicle? YES NO
2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? YES NO
3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? YES NO
4. 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
5. Does the applicant have a history of liver disease of any origin? YES NO
   If YES, please give details in section 6
6. Is there a history of renal failure? YES NO
   If YES, please give details in section 6
7. Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive sleepiness? YES NO
   If YES, please give diagnosis
   a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity
      Mild (AHI <15) YES NO
      Moderate (AHI 15 - 29) YES NO
      Severe (AHI >29) YES NO
      Not known YES NO
      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 6.
   b) Please answer questions i – 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
      (vi) Date of last review YES NO

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 provide details of medication and symptoms in section 6

10. Does the applicant have an ophthalmic condition? YES NO
   If YES, please provide details in section 6

11. Does the applicant have any other medical condition that could affect safe driving? YES NO
   If YES, please provide details in section 6

6 Further details

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

Applicant's full name

Date of birth D D M M Y Y
### Consultants' details

Details of type of specialist(s)/consultants, including address.

<table>
<thead>
<tr>
<th>Consultant in</th>
<th>Name</th>
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Date of last appointment: **DDMMYYYY**

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Date of last appointment: **DDMMYYYY**

### Medication

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

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<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Reason for taking:</th>
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### Examining doctor's details

To be completed by the doctor carrying out the examination.

Please ensure all sections of the form have been completed. Failure to do so will result in the form being returned to you.

**Please print name and address in capital letters**

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<th>Phone</th>
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I confirm that this report was completed by me at examination and that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside of the UK.

**Signature of practitioner**

<table>
<thead>
<tr>
<th>Date of signature</th>
<th><strong>DDMMYYYY</strong></th>
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**GMC registration number**

**Doctors stamp**

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**Applicant's full name**

Date of birth: **DDMMYYYY**
This page must be completed by the applicant
Applicant’s consent and 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 consent**
As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination or some form of practical assessment. If we do, the people involved will need your background medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the assessment of your fitness to drive will be released. In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

**Consent and declaration**
I authorise my doctor(s) and specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State's medical adviser.
I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to doctors, paramedical staff and 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.

<table>
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<th>Name</th>
<th>__________________________________________</th>
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<tbody>
<tr>
<td>Signature</td>
<td>_________________________________________</td>
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<td>Date</td>
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I authorise the Secretary of State to:  

- Inform my doctors about the outcome of my case  
- Release reports to my doctor(s)  

Check list
- Have you signed and dated the consent and declaration?  
- Have you checked that the report has been fully filled in by the optician/doctor?

**This report must be completed no more than 4 months before the date your application is received at DVLA and must be returned with your application form.**