



TPH/204

Medical Declaration

For LTPH use only

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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 individual's 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:

London Taxi and Private Hire
Palestra
4th Floor Green Zone
197 Blackfriars Road
London SE1 8NJ

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 Forename(s)

A3 Date of Birth

D	D	M	M	Y	Y	Y	Y
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A4 Current address

Postcode

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House number

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Rest of address

B - Registered GP Details

B1 Name of Registered GP

B2 Address

Postcode

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Premises number

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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 hereby consent to Transport for London (TfL) and their medical advisers processing personal data relating to my medical condition 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

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Date

D	D	M	M	Y	Y	Y	Y
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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

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

Yes	No
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

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

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

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

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

If 'Yes', please give date of most recent intervention:

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

(d) Angina

If 'Yes', please give date of the last known attack:

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

(e) Heart failure

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
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(f) Implantable Cardioverter Defibrillator (ICD)

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
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(g) Any other coronary artery procedure

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" 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 cardio-vascular disorders/procedures

Does the applicant have a history of:

(a) Cardiac arrhythmia

If 'Yes', when was the last recorded occurrence?

AND complete question 3(c)

Yes	No
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

(b) Peripheral arterial disease

<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" 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 cardio-vascular disorders/procedures

Does the applicant have a history of:

	Yes	No
(a) Aortic aneurysm If 'Yes', please provide the following:	<input type="checkbox"/>	<input type="checkbox"/>
(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"/>	
(b) Dissection of the aorta If 'Yes', please provide copies of all reports to include those dealing with any surgical treatment	<input type="checkbox"/>	<input type="checkbox"/>
(c) Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
(d) Systolic reading consistently above 180/diastolic reading consistently above 100	<input type="checkbox"/>	<input type="checkbox"/>
(e) Please provide a current blood pressure reading		
(f) Cardiomyopathy If 'Yes', please state which type: AND provide full details in section E (on page 8)	<input type="checkbox"/>	<input type="checkbox"/>
(g) Congenital heart disorders	<input type="checkbox"/>	<input type="checkbox"/>
(h) 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 If 'Yes', please give date and provide full details in section E (on page 8)	<input type="checkbox"/>	<input type="checkbox"/>
	<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 If 'Yes', please give date and provide full details in section E (on page 8)	<input type="checkbox"/>	<input type="checkbox"/>
	<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? Please provide the reading (e.g. 40% or 0.4): Please provide the date reading was taken AND provide full details in section E (on page 8)	<input type="checkbox"/>	<input type="checkbox"/>
	<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"/> <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

(a) Does the applicant have diabetes mellitus?

If 'No', please continue to question 6

If 'Yes', is it managed by:

(i) Diet alone

(ii) Oral hypoglycaemic agents not likely to cause hypoglycaemia (including metformin)

(iii) Oral hypoglycaemic agents with potential to cause hypoglycaemia including gliptins, sulphonyurea, glinides, exenatide, and/or others

If 'Yes' please give date started on agents and complete **ALL** of question (b) below

(iv) Insulin

If 'Yes' please give date started on insulin and complete **ALL** of question (b) below

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

<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="checkbox"/>	<input type="checkbox"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(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)**

(ii) Does the applicant have a history of responsible diabetic control **(If 'No' please provide further details below)**

(iii) Does the applicant have good hypoglycaemic awareness **(If 'No' please provide further details below)**

(iv) As far as you know, is the applicant adherent to treatment protocols, twice daily blood sugar measurements and at times relevant to driving **(If 'No' please provide further details below)**

(v) Is the applicant at minimal risk (i.e. Low risk) of hypoglycaemic attack resulting in incapacity **(If 'No' please provide further details below)**

(vi) Does the applicant have any complications of diabetes which may interfere with driving **(If 'Yes' please provide further details below)**

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

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

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

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

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

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

(b) A first unprovoked epileptic seizure/solitary fit within the last 5 years

(c) Blackout/Impairment of Consciousness

(d) Stroke/TIA

If 'Yes', please give the date **and** complete ALL the questions below:

D		D		M		M		Y		Y		Y		Y
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(i) Has there been a **full** recovery?

(ii) Is there any debarring residual impairment that would affect safe driving?

(iii) Any other significant risk factors?

(iv) Is there imaging evidence of less than 50% carotid artery stenosis?

(v) Has exercise/functional testing been undertaken?

If 'Yes', please ensure you complete **question 3** of this form (on page 4)

(e) Sudden Disabling Dizziness/Vertigo

(f) Pathological Sleep Disorder

(g) Chronic and/or Progressive Neurological Disorder

(h) Brain Surgery

(i) Serious Head Injury

(j) Brain Tumour

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

(b) Psychotic Illness

(c) Dementia /Cognitive Impairment

(d) Alcohol Misuse

(e) Alcohol Dependency

(f) Drug or Substance Misuse

(g) Drug or Substance Dependency

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" value="dioptr<sup>es</sup>"/>
Right	<input type="text"/>	<input type="text"/>	<input type="text" value="dioptr<sup>es</sup>"/>

In addition, the visual acuity (with the aid of glasses or contact lenses if worn) 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.

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

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?	<input type="text"/>	<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

F - Declaration - to be completed by GP

I certify that, at the time of examination and completion of this medical form, I had possession of the applicants complete medical history.

Signature

Date

D	D	M	M	Y	Y	Y	Y
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Name (BLOCK CAPITALS)

Surgery Stamp