

MEDICAL IN CONFIDENCE -

IMPORTANT: All medicals completed for ERYC Hackney Carriage or Private Hire Vehicle Driver's Licences MUST be completed by the applicants Registered General Practitioner or a partner in the same practice who has access to your full historic and current medical history.

For the Applicant:

This Certificate is the method by which the East Riding of Yorkshire Licensing Authority is advised that the Applicant is considered medically fit to drive hackney carriage/private hire vehicles.

Applicants must be examined and certified as being medically fit (to a Group 2 Standard) by their registered GP or another GP in the same practice with which they are registered, who must have taken into account previous medical history. The Council may require a further examination or referral following this initial certification.

This certificate is not one which must be issued free of charge as part of the National Health Service. The Council accepts no liability to pay for it.

For the Applicants Doctor:

This certificate is for the confidential use of the East Riding of Yorkshire Council,

East Riding of Yorkshire Council has adopted the Group 2 Medical Standards for Fitness to Drive Hackney Carriage and Private Hire Vehicles in accordance with the DVLA and Department for Transport Best Practice Guidance.

The C1 criteria for insulin treated diabetes is adopted in relation to hackney carriage and private hire drivers.

Group 2 Medical reports are only accepted from the applicant's own registered doctor, or another doctor in the same practice, taking into account an applicant's full medical records.

In completing this certificate, GPs are asked to have regard to the booklet "At a Glance Guidance to the Current Standards of Fitness to Drive" (current edition) issued the Drivers Medical Group, DVLA, Swansea.

When making an application: This medical form will only be valid for 6 weeks following the date of the medical assessment being carried out.

Medicals must be completed every 5 years until the age 65. From age 65 medical examinations must be completed annually.

***Unless the GP specifies a more regular interval, your medical will automatically expire as above.**

What do you have to do?

1. **Before** consulting your Doctor please read the notes overleaf at **Section C, paragraphs 1, 2 and 3.** If you have any these conditions you will **NOT** be granted this licence.
2. If, after reading the notes, you have any doubts about your ability to meet the medical or eyesight standards, consult your Doctor/Optician **BEFORE** you can arrange for this medical form to be completed. The Doctor will normally charge you for completing it. In the event of your application being refused, the fee you pay the Doctor is **NOT** refundable.
The East Riding of Yorkshire Council has **NO** responsibility for the fee payable to the Doctor.
3. Fill in **Section 8 and Section 9 on pages 11 and 12** of this report in the presence of the Doctor carrying out the examination.
4. This medical report must be sent to the East Riding of Yorkshire Council's Licensing Team by your GP if you are an existing licensed driver with East Riding of Yorkshire Council or given to you (as the applicant) to submit with your complete application as a new applicant.

What the doctor has to do?

1. **Please arrange for the patient to be seen and examined.**
2. Please complete sections 1-7 and 10 of this report You may find it helpful to consult DVLA's "At a Glance" and the Medical Commission on Accident Prevention booklet – "Medical Aspects of Fitness to Drive" which the East Riding of Yorkshire Council has formally adopted. Further help can be obtained by telephoning 0300 790 6806 and asking to speak to one of the DVLA Medical Advisers. They would need to know the applicant's full name, address and date of birth. They would also need to know in addition your name, the surgery address and phone number and a time when it might be convenient to return your call.
3. Applicants who may be asymptomatic at the time of the examination should be advised that, if in future they develop symptoms of a condition which could affect safe driving and they hold any type of driving licence, they must inform Drivers Medical Group, D7, DVLA, Swansea SA99 1TU – immediately.
4. Please ensure that you have completed all the sections.
5. Once completed please either return to the following address for existing licensed drivers;

Licensing Team, County Hall, Cross Street, Beverley, HU17 9BA.

Or if the patient is a new applicant for a Hackney Carriage/Private Hire driver's licence, please give the completed form to the applicant.

If this report does not bring out important clinical details with respect to driving, please give details in Section 7.

GP Signature

Date

C Medical Standards for drivers of Hackney Carriage and Private Hire Vehicles

The following conditions are a bar to the holding of any of these entitlements.

1. **Epileptic attack**

Applicants must have been free of epileptic seizures for at **least the last ten years** and have not taken anti epileptic medication during this ten year period. The East Riding of Yorkshire Council will refuse or revoke the licence if these conditions cannot be met.

2. **Diabetes**

Insulin treated diabetics may **not** obtain a licence unless they held an East Riding of Yorkshire Council Hackney Carriage or Private Hire Vehicle Driver's Licence valid at 1 April 1991 and the East Riding of Yorkshire Council had knowledge of the insulin treatment before 1 January 1991.

3. **Eyesight**

The visual acuity, as measured by the 6 metre snellen chart must be at least 6/7.5 (decimal snellen equivalent 0.8) in the better eye and at least snellen 6/60 (decimal snellen equivalent 0.1) in the other eye. Corrective lenses may be worn to achieve this standard. A LogMAR reading is acceptable.

(ii) Applicants are also banned from holding a Hackney Carriage or Private Hire Vehicle Driver's Licence if they have:

- **Uncontrolled diplopia (double vision)**
- **Or do not have a normal binocular field of vision**

An applicant (or existing licence holder) failing to meet the epilepsy, diabetes or eyesight regulations will be refused a licence.

4. **Other medical conditions**

In addition to those medical conditions covered by law, applicants (or licence holders) are likely to be refused if they are unable to meet the national recommended guidelines in the following cases:

- Within 3 months of myocardial infarction, any episode of unstable angina, CABG or coronary angioplasty
- A significant disturbance of cardiac rhythm occurring within the past 5 years unless special criteria are met
- Suffering from or receiving medication for angina or heart failure
- Hypertension where the BP is persistently 180 systolic or over or 100 diastolic or over
- A stroke, or TIA within the last 12 months
- Unexplained loss of consciousness within the past 5 years
- Meniere's and other conditions causing disabling vertigo, within the past 1 year, and with a liability to recurrence
- Recent severe head injury with serious continuing after effects, or major brain surgery

GP Signature

Date

- Parkinson's disease, multiple sclerosis or other "chronic" neurological disorders likely to affect limb power and co-ordination
- Suffering from a psychotic illness in the past 3 years, or suffering from dementia
- Alcohol dependency or misuse, or persistent drug or substance misuse or dependency in the past 3 years
- insuperable difficulty in communicating by telephone in an emergency
- any other serious medical condition which may cause problems for road safety when driving a licensed vehicle if major psychotropic or neuroleptic medication is being taken
- any malignant condition within the last 2 years likely to metastasise to the brain e.g. Cancer of lung or malignant melanoma.

GP Signature

Date

Medical Examination

Please answer all questions

Please give patient's weight kg/st and height ft/cms

Please give details of smoking habits, if any

Please give number of alcohol units taken each week

1 Vision

Date when first licensed to drive a Hackney Carriage or Private Hire Vehicle.

1. Please confirm the scale you are using to express the driver's visual acuities. (Tick as appropriate)

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 are not met, the applicant may need further assessment by an optician.

Uncorrected

R	L
---	---

Corrected

(Using the prescription worn for driving)

R	L
---	---

3. Please give the best binocular acuity with corrective lenses if worn for driving.

4. 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**

5. Were corrective lenses worn to meet this standard?
If **yes**, glasses contact lenses both together

6. If glasses (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?

7. If correction is worn for driving, is it well tolerated?

If you answer **Yes** to ANY of the following (6 to 9), give details in the box provided over leaf.

GP Signature

Date

- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 8. Is there a history of medical condition that may affect the applicants binocular field of vision (central and/or peripheral)? | <input type="checkbox"/> | <input type="checkbox"/> |

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

- | | | |
|-----------------------|--------------------------|--------------------------|
| 9. Is there diplopia? | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) Is it controlled? | <input type="checkbox"/> | <input type="checkbox"/> |
- If **Yes**, please ensure you give full details in the box provided.

- | | | |
|--|--------------------------|--------------------------|
| 10. Does the applicant on questioning, report symptoms of intolerance to glare and/ or impaired contrast sensitivity and/ or impaired twilight vision? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- | | | |
|---|--------------------------|--------------------------|
| 11. Does the applicant have any other ophthalmic condition? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

If yes to any of the questions relating to visual health, please give full details below.

Details

Date of examination

Name (print)

Signature

Date of signature

Please provide your GOC, HPC or GMC number

Doctor/Optomertist/Optician's Stamp

GP Signature

Date

2 Nervous System

Please tick the appropriate box(es)

Is there a history of, or evidence of any neurological disorder?
 If **NO**, go to section 2
 If **YES**, please answer all the questions below, give full details
 Including any relevant hospital notes.

YES NO

1. Has the applicant had any form of seizure?

If **NO**, please go to **question 3**

If **YES**, please answer questions a-f

(a) Has the applicant had more than one attack?

(b) Please give date of first and last attack

First attack D D M M Y Y

Last attack D D M M Y Y

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

If **YES**, please fill in current medication in **section 9**

(d) If no longer treated, please give date when treatment ended

D D M M Y Y

(e) Has the applicant had a brain scan?

If **YES**, please give details in section 6

(f) Has the applicant had an EEG?

If **YES** to any of above, please supply reports if available.

YES NO

2. Stroke or TIA?

If yes, please give date

a. Has there been a **FULL** recovery?

b. Has a carotid ultra sound been undertaken?

c. If **yes**, was the carotid artery stenosis >50% in either carotid artery?

d. Has there been a carotid endarterectomy?

3. Sudden and disabling dizziness/ vertigo within the last year with a liability to recur?

4. Serious traumatic brain injury within the last 10 years?

5. Any form of brain tumor?

6. Other brain surgery or abnormality?

GP Signature

Date

- | | YES | NO |
|--|--------------------------|--------------------------|
| 7. Chronic neurological disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Parkinson's disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Is there a history of blackout or impaired consciousness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does the applicant suffer from narcolepsy? | <input type="checkbox"/> | <input type="checkbox"/> |

3 Diabetes Mellitus

Please tick the appropriate box(es)

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Does the applicant have diabetes mellitus?
If NO , please go to section 4
If YES , please answer the following questions. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the diabetes managed by:-
(a) Insulin?
If YES , please give date started on insulin | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> Y <input type="checkbox"/> Y | | |
| (b) If treated with insulin, are there at least 3 months of blood glucose reading stored on a memory meter(s)?
If NO , please give details in section 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Other injectable treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) A Sulphonylurea or a Glinide? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Oral hypoglycaemic agents and diet?
If YES , to any of a-e, please fill in current medication in section 9 | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Diet only? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. (a) Does the applicant test blood glucose at least twice every day? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Does the applicant test at times relevant to driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Does the applicant keep fast acting carbohydrate within easy reach when driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is there any evidence of impaired awareness of hypoglycaemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? | <input type="checkbox"/> | <input type="checkbox"/> |

GP Signature

Date

Applicant Name

DOB

6. Is there evidence of:-
(a) Loss of visual field?

YES NO

(b) Sever peripheral neuropathy, sufficient to impair limb function for safe driving?

If YES to any of 4-6 above, please give details in section 7

7. Has there been laser treatment or intra-vitreous treatment for retinopathy?

If YES, please give date(s) of treatment.

4 Psychiatric Illness

Is there a history of, or evidence of, **ANY** of the conditions listed at 1-7 below?

- Please enclose relevant hospital notes
- If applicant remains under specialist clinic(s), ensure details are filled in at section 7.

1. Significant psychiatric disorder within the past 6 months

YES NO

2. Psychosis or hypomania/mania within the past 3 years, including psychotic depression

3. Dementia or cognitive impairment

4. Persistent alcohol misuse in the past 12 month

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 of questions 4-7, please state how long this has been controlled

Please give details of past consumption or name drug(s) and frequency

5 Cardiac

5A Cardiac

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

YES NO

GP Signature

Date

If **NO**, go to **section 5B**

If **YES**, please answer all questions below and give details at section 7 of the form and enclose relevant hospital notes.

1. Has the applicant suffered from Angina?
If **YES**, please give the date of last know attack.

D	D	M	M	Y	Y
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2. Acute coronary syndromes including Myocardial infarction?
If **YES**, please give date.

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

3. Coronary angioplasty (P.C. 1)?
If **YES**, please give date of most recent intervention .

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

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

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

5B Cardiac Arrhythmia

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

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

If **NO**, go to **section 5C**

If **YES**, please answer all question below and give details in **section 7**

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

2. Has the arrhythmia been controlled satisfactory for at least 3 months?

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

4. Has a pacemaker been impanted?
If **YES**:-
(a) Please supply date of implantation?

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

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

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

GP Signature

Date

5C Peripheral arterial disease (excluding buerger's disease) aortic aneurysm/dissection

Is there a history or evidence of **ANY** of the following: YES NO

If **NO**, go to **section 5D**.

If **YES**, please answer all questions below and give details in **section 7**

1. Peripheral arterial disease (excluding Buerger's disease) YES NO
-

2. Does the applicant have claudication?
If **YES**, how long in minute can the applicant walk at a brisk pace before being symptom-limited?

Please give details

3. Aortic aneurysm YES NO
- If **YES**:
- (a) Site of Aneurysm: Thoracic Abdominal
- (b) Has it been repaired successfully? YES NO
- (c) Is the transverse diameter currently > 5.5cm? YES NO

If **NO**, please provide latest measurement and date obtained

4. Dissection of the aorta repaired successfully YES NO
If **YES**, please provide copies of all reports to include dealing with any surgical treatment.
5. Is there a history of Marfan's disease? YES NO
If **YES**, provide relevant hospital notes

5D Valvular/Congenital Heart Disease

Is there a history of, or evidence of, Valvular/congenital heart disease? YES NO

If **NO**, go to **section 5E**

If **YES**, please answer all questions below and give details in **section 7** of the form.

1. Is there a history of congenital heart disorder? YES NO
2. Is there a history of heart valve disease? YES NO
3. Is there any history of embolism? (**not** pulmonary embolism) YES NO
4. Does the applicant currently have significant symptoms? YES NO
5. Has there been any progression since the last licence application? (if relevant) YES NO

GP Signature

Date

5E Cardiac Other

Does the applicant have a history of **ANY** of the following conditions: **YES** **NO**

If **NO**, go to **section 5F**
 If **YES**, please answer **ALL** questions and give details in **section 7**

- (a) A history of, or evidence of, heart failure?
- (b) Establishment cardiomyopathy?
- (c) Has a left Ventricular Assist Device (LVAD) been implanted?
- (d) A heart or heart/lung transplant?
- (e) Untreated atrial myxoma

5F Cardiac Investigation

This section must be filled in for all applicants

- 1.** Has a resting ECG been undertaken? **YES** **NO**
 If **YES**, does it show:-
- (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**.

- 2.** Has an exercise ECG been undertaken (or planned)?

If **YES**, please give date and give details in **section 6**

Please provide relevant report if available

- 3.** Has an echocardiogram been undertaken (or planned)?

(a) If **YES**, please give date and give details in **section 7**

(b) If undertaken, is/was the left ejection fraction greater than or equal to 40%?

Please provide relevant report if available

- 4.** Has a coronary angiogram been undertaken (or planned)? **YES** **NO**

If **YES**, please give date and give details in **section 7**

GP Signature Date

Please provide relevant reports if available

5. Has a 24 hour ECG tape been undertaken (or planned)?

If **YES**, please give date and give details in **section 7**

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

Please provide relevant reports if available

6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?

If **YES**, please give date and give details in **section 7**

D	D	M	M	Y	Y
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Please provide relevant reports if available

5G Blood Pressure

1. Please record today's blood pressure reading

2. Is the applicant on anti-hypertensive treatment?

If **YES** provide three previous reading with dates if available

<input type="text"/>	D	D	M	M	Y	Y
<input type="text"/>	D	D	M	M	Y	Y
<input type="text"/>	D	D	M	M	Y	Y

6 General

Please answer **ALL** questions. I '**YES**' to any give full details in **section 7**

1. Is there **currently** any functional impairment that is likely to affect control of the vehicle?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>

2. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally?

<input type="checkbox"/>	<input type="checkbox"/>
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3. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?

<input type="checkbox"/>	<input type="checkbox"/>
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4. Is the applicant profoundly deaf?

<input type="checkbox"/>	<input type="checkbox"/>
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If **YES**, is the applicant able to communicate in the event of an emergency to speech or by using a device e.g. a textphone?

<input type="checkbox"/>	<input type="checkbox"/>
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5. Does the applicant have a history of liver disease of any origin?

<input type="checkbox"/>	<input type="checkbox"/>
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GP Signature

Date

If **YES**, please give details in **section 7**

6. Is there a history a renal failure?

If **YES**, please give details in **section 7**

7. (a) Is there a history of, or evidence of obstructive sleep apnoea syndrome?

- (b) Is there any other **medical condition** causing excessive daytime sleepiness?

If **YES**, please give details diagnosis

If **YES**, to 7a or b please give

- (a) Date of diagnosis

- (ii) Is it controlled successfully?

(iii) If **YES**, please state treatment

(iv) Please state period of control

(v) Date last seen by consultant

YES **NO**

8. Does the applicant have sever symptomatic respiratory disease causing chronic hypoxia?

9. Does any medication currently taken cause the applicant side effects that could affect safe driving?

If **YES**, please provide details of medication and symptoms in **section 7**

10. Does the applicant have an ophthalmic condition?

If **YES**, please provide details in **section 7**

11. Does the applicant have any other medical condition that could provide details in **section 7**

If **YES**, please provide details in **section 7**

GP Signature

Date

7 Further Details

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

8 Consultants details

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

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

Consultant in
Name
Address

Date of last appointment

GP Signature

Date

9 Medication

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

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

Medication	Dosage
Reason for taking:	

8 Applicant's consent and declaration

Consent and Declaration

This section must be completed and must not be altered in any way.

Please sign the statements below.

I authorise my registered Doctor(s) and Specialist(s) to release reports to the East Riding of Yorkshire Council's Licensing Team about my medical condition.

I authorise the Secretary of State and his representatives to divulge relevant medical information about me to Doctors or Paramedical staff (including the East Riding of Yorkshire Council's Licensing Team's Doctor) as necessary in the course of medical enquiry into my fitness to drive.

I declare that I have checked the details I have given on the enclosed questionnaire and that to the best of my knowledge they are correct.

Signature

Date

I authorise the East Riding of Yorkshire Council's Licensing Team to release medical information to my Doctors and or Specialists about the outcome of my case. (This is to enable your Doctor to advise you about the fitness to drive)

Signature

Date

GP Signature

Date

Note about consent You will see that we have asked for your consent, not only for the release of medical reports from your doctors, but also that we might in our turn very occasionally release medical information to Doctors or Paramedical staff, either because we wish you to be examined, and the doctors need to know the medical details, or because we require further information. You need to understand quite clearly how we define Paramedical staff. Many patients need to be assessed in Driving Assessment Centres who employ Occupational Therapists, Physiotherapists, Orthoptists and experienced driving instructors, all of who need to understand about a patient's medical condition in order to produce a helpful report. Only occasionally do we need to do this and it may well not apply in your case. We never under any circumstances release information which is not relevant to fitness to drive, nor would we expect to receive this from your Doctors.

We hope you will find this helpful and reassuring and will return the signed consent so that we might proceed with our investigations.

Applicant Name

DOB

GP Signature

Date

Applicant's Details

To be completed in the presence of the Registered GP carrying out the examination.

Please make sure that you have printed your name and date of birth on each page before sending this form with your application.

9 Your Details

<i>Your Name</i>	<i>Date of Birth</i>	
<i>Your Address</i>	<i>Telephone – Home</i>	
	<i>Daytime/ work</i>	

About your GP/Group Practice

About your Consultant/Specialist current or previous (if applicable)

<i>GP/Group Name</i>		<i>Consultants Name</i>	
<i>Address</i>		<i>Address</i>	
<i>Telephone</i>		<i>Telephone</i>	

Date Last Seen

GP Signature

Date

12. Medical Practitioner Details

To be completed by the Registered GP carrying out the examination

I CERTIFY that I am the **registered GP of** the applicant named below and that I have full access to their historic medical records to complete this form.

I certify that I have this day examined the applicant, who has signed this form in my presence.

Does the applicant in your opinion meet the standard of medical fitness required for a Group2 driver as set out in the current edition of "Medical Aspects of Fitness to Drive" and DVLA's "At a Glance"?

Signature of Medical Practitioner.....

<i>Name of applicant</i>	
<i>Address</i>	
Does the applicant in your opinion meet the standard of medical fitness required for a Group2 driver as set out in the current edition of "Medical Aspects of Fitness to Drive" and DVLA's "At a Glance"?	Yes/No Comments:
Is there any abnormality present that is not included in the above questions?	
Do you consider future examination necessary? Is so, in what period of time?	

Signature of Registered GP

Date

IMPORTANT: in line with the Council's policy All medicals for ERYC Hackney Carriage or Private Hire Vehicle Driver's Licences MUST be completed by the applicants own Registered General Practitioner or partner at the GP's Practice.

GP Signature

Date

ONCE COMPLETED, THE GP SHOULD FORWARD THIS MEDICAL REPORT MARKED 'PRIVATE & CONFIDENTIAL' TO:

**East Riding of Yorkshire Council
Licensing Team
County Hall
Cross Street
Beverley
HU17 9BA**

Or email to taxi.hub@eastriding.gov.uk

GP Signature

Date