This document is valid for use between 1 January and 31 December 2022, subject to legal amendments.

City of Wolverhampton Council Licensing Services

Hackney Carriages and Private Hire Drivers Medical Certificate

Full Name of Applicant (CAPITALS)_____

Address_____**Postcode**_____

I hereby authorise my doctor(s) and specialists to release reports/medical information to the Medical Practitioner, should they require further information about condition(s) relevant to my fitness to drive to group 2 standard.

Signature of applicant _____

(To be signed in the presence of the medical practitioner signing this certificate)

You are 'Assessing Fitness to Drive' at DVLA Group 2 Standard, a guidance for medical professionals is available online at https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals
This medical must be completed in person and not remotely.

The applicant has provided one from each type of the following forms of identification,

Type 1: Passport ❑ Driving Licence ❑

Type 2: Utility Bill (gas, electric, telephone, water) ❑ Bank Statement ❑

Birth Certificate ❑ Marriage/ Civil Partnership Certificate ❑

Date of Birth of applicant_____/_____/_____ **Age of applicant**_____

Medical certification frequency requirement

- A new certificate must be produced every 5 years after the applicant's 45th birthday.
- Once the age of 65 is reached, a medical certificate must be produced every year.

Earlier medical certification frequency requirement

The above medical certification frequency is not sufficient: ❑ (tick box, **if applicable**) and I recommend that the applicant is examined no later than: (insert date) _____

I certify that I have on this day examined the applicant, who signed this form in my physical presence and showed two forms of identification as indicated above, who is in my opinion,

Medically fit ❑ **Medically unfit** ❑ to drive a hackney carriage or private hire vehicle.

Signature of GMC registered Medical Practitioner_____ **Date**____/____/2022

GMC Reference Number

Name (CAPITALS)_____

Please add address and phone number
or Medical Practice Address Stamp
No disclaimers are acceptable.

Please note – this certificate is only valid from four months from the date of assessment.