







**1 Neurological disorders**

Please tick ✓ the appropriate boxes  
Is there 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 and enclose relevant hospital notes.

- 1. Has the applicant had any form of seizure? Yes No
  - (a) Has the applicant had more than one seizure episode? Yes No
  - (b) If Yes, please give date of first and last episode.
 

First episode	DD	MM	YY
Last episode	DD	MM	YY
  - (c) Is the applicant currently on anti-epileptic medication? Yes No  
If Yes, please fill in the medication section 8, page 6.
  - (d) If no longer treated, when did treatment end? DDMMYY
  - (e) Has the applicant had a brain scan? Yes No  
If Yes, please give details in section 9, page 7.
  - (f) Has the applicant had an EEG? Yes No  
If you have answered Yes to any of above, you must supply medical reports.
- 2. Has the applicant experienced dissociative/'non-epileptic' seizures? Yes No
  - (a) If Yes, please give date of most recent episode. DDMMYY
  - (b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving? Yes No
- 3. Stroke or TIA? Yes No  
If Yes, give date. DDMMYY
  - (a) Has there been a full recovery? Yes No
  - (b) Has a carotid ultrasound been undertaken? Yes No
  - (c) If Yes, was the carotid artery stenosis >50% in either carotid artery? Yes No
  - (d) Is there a history of multiple strokes/TIAs? Yes No
- 4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur? Yes No
- 5. Subarachnoid haemorrhage (non-traumatic)? Yes No
- 6. Significant head injury within the last 10 years? Yes No
- 7. Any form of brain tumour? Yes No
- 8. Other intracranial pathology? Yes No
- 9. Chronic neurological disorder(s)? Yes No
- 10. Parkinson's disease? Yes No
- 11. Blackout, impaired consciousness or loss of awareness within the last 10 years? Yes No

**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 managed by: Yes No
    - (a) Insulin? Yes No  
If No, go to 1c
    - If Yes, please give date started on insulin. DDMMYY
    - (b) Are there at least 3 continuous months of blood glucose readings stored on a memory meter or meters? Yes No  
If No, please give details in section 9, page 7.
    - (c) Other injectable treatments? Yes No
    - (d) A Sulphonylurea or a Glinide? Yes No
    - (e) Oral hypoglycaemic agents and diet? Yes No  
If Yes to any of (a) to (e), please fill in the medication section 8, page 6.
    - (f) Diet only? Yes No
  - 2. (a) Does the applicant test blood glucose at least twice every day? Yes No
  - (b) Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every 2 hours while driving)? Yes No
  - (c) Does the applicant keep fast-acting carbohydrate within easy reach when driving? Yes No
  - (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? Yes No
  - 3. (a) Has the applicant ever had a hypoglycaemic episode? Yes No
  - (b) If Yes, is there full awareness of hypoglycaemia? Yes No
  - 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. Is there evidence of: Yes No
    - (a) Loss of visual field? Yes No
    - (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? Yes No
 If Yes, please give details in section 9, page 7.
  - 6. Has there been laser treatment or intra-vitreous treatment for retinopathy? Yes No  
If Yes, please give most recent date of treatment. DDMMYY

<b>Applicant's full name</b>		<b>Date of birth</b>	
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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 7, Further details.

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

(i) Date of diagnosis:       Yes  No

(ii) Is it controlled successfully?

(iii) If Yes, please state treatment.

(iv) Is applicant compliant with treatment? Yes  No

(v) Please state period of control:

years  months

(vi) Date of last review.

## 7 Other medical conditions

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

2. Is there currently any functional impairment that is likely to affect control of the vehicle? Yes  No

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? Yes  No

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

5. 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

6. 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 7.

7. Is there a history of renal failure? Yes  No

If Yes, please give details in section 9, page 7.

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 fill in section 8, Medication and give symptoms in section 9, page 7.

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

If Yes, please provide details in section 9, page 7.

## 8 Medication

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

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

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Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Applicant's full name

Date of birth



## 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 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 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 medical assessment of your fitness to drive. Also, 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. Panel members must adhere strictly to the principle of confidentiality.

#### Declaration

I authorise my doctor and specialist to release reports and information about my condition which is relevant to my fitness to drive, to the Secretary of State's medical adviser.

I understand that the Secretary of State may disclose relevant medical information that is necessary to investigate 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.

Name

Signature

Date

I authorise the Secretary of State to:

	Yes	No
inform my doctors about the outcome of my case	<input type="checkbox"/>	<input type="checkbox"/>
release reports to my doctor(s)	<input type="checkbox"/>	<input type="checkbox"/>

Contact me about my application by:

	Yes	No
email	<input type="checkbox"/>	<input type="checkbox"/>
SMS (text message)	<input type="checkbox"/>	<input type="checkbox"/>

**(Please note: DVLA will continue to contact you by post if you do not wish to be contacted by email or text.)**

Checklist	Yes
• Have you signed and dated the declaration?	<input type="checkbox"/>
• Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?	<input type="checkbox"/>

#### 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.**