



*Basingstoke
and Deane*

LICENSING

REPORT OF MEDICAL EXAMINATION OF APPLICANT FOR HACKNEY CARRIAGE OR PRIVATE HIRE DRIVER'S LICENCE

Local Government (Miscellaneous Provisions) Act 1976

FRONT PAGE TO BE COMPLETED BY APPLICANT

To to completed in the presence of the Medical Practitioner carrying out the examination

Name of Applicant:	
Address of Applicant:	
Postcode:	
Contact Phone No.:	E-mail Address:
Date of Birth:	
Is this a new application? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Badge No: <input style="width: 150px;" type="text"/>	Date First Issued: <input style="width: 150px;" type="text"/>
Name and address of doctor applicant is registered with:	
<p>APPLICANT'S DECLARATION AND CONSENT Please read the following carefully and sign the statements below:</p> <p>"I have read the notes overleaf and give my consent for the Council's Medical Advisor to consult my doctor(s) and specialist(s) regarding my medical examination for a Hackney Carriage or Private Hire driver's licence. I also give consent for my doctor(s) and specialist(s) to release information to the Council's Medical Adviser. I understand the information in this report will be retained by the Licensing Department on a confidential basis."</p>	
Signed: <input style="width: 150px; height: 40px;" type="text"/>	Date: <input style="width: 150px; height: 40px;" type="text"/>

Please forward this completed report to:

The Licensing Team, Basingstoke and Deane Borough Council, Civic Offices, London Road, Basingstoke, Hampshire, RG21 4AH
If you have any queries please contact the Licensing Team at the above address or telephone: 01256 845374 Fax: 01256 845200 E-mail: licensing@basingstoke.gov.uk

Any fee charged is payable by the applicant to the Medical Practitioner.

MEDFORM

MEDFORM

Information and Useful Notes for Applicants and Doctors

The House of Commons Transport Select Committee on taxis and private hire vehicles recommended in February 1995 that applicants for a licence to drive such vehicles should pass a medical examination before a licence could be granted.

Responsibility for determining the standards (including medical requirements) to be applied to taxi and private hire drivers, over and above car driver licensing requirements, rests with the local authority. Current guidance by the medical commission on accident prevention recommends that the Group 2 medical standards as applied by DVLA should also be applied by local authorities to taxi and private hire drivers.

In line with the above, Basingstoke and Deane Borough Council require all new applicants to undergo a medical for the purpose of assessing their fitness to hold a private hire or hackney carriage licence. Current drivers are required to undergo a medical every five years, or annually on renewal once they reach the age of 65. Additional medical assessment or tests may be required as advised by the council's medical adviser.

Group 2 Medical Standards

Medical standards for Group 2 are very much higher than those applied to Group 1, reflecting the high risk caused by the length of time the driver may spend at the wheel in the course of their occupation. (Group 1 includes motor cars and motor cycles.) The following conditions are a bar to meeting Group 2 standards:

1. Epilepsy or liability to epileptic attacks

A diagnosis of epilepsy or spontaneous epileptic attack(s) requires 10 years free of further epileptic attack without taking anti-epilepsy medication during that 10-year period.

2. Diabetes

New drivers from 1 April 1991 with insulin treated diabetes may NOT obtain a licence. Drivers licensed before 1 April 1991 where the Traffic Commissioner had knowledge of the insulin treatment before 1 January 1991, are dealt with individually and licensed subject to satisfactory annual consultation assessment. Regulation changes in April 2001 allow 'exceptional case' drivers to apply under qualifying conditions to drive light trucks however, this excludes minibuses.

3. Eyesight

All applicants, for any category of vehicle, must be able to read in good light with glasses or corrective lenses if necessary, a number plate at 20.5 metres (67 feet) or 20 metres (65 feet) where narrower characters are displayed (50mm wide). The characters displayed on all new and replacement number plates manufactured from September 2001 are 50mm in width instead of 57mm.

In addition to meet Group 2 standards an applicants must by law have:

- A visual acuity of at least 6/9 in the better eye; and
- A visual acuity of at least 6/12 in the worse eye; and
- If these are achieved by correction, the uncorrected visual acuity in each eye must be no less than 3/60.

Normal binocular field of vision is required i.e. Any area of defect in a single eye is totally compensated for by the field of the other eye. Complete loss of vision in one eye or corrected acuity of less than 3/60 in one eye would be mean the applicant is barred from holding a Group 2 licence.

Grandfather rights apply in some instances regarding the above. To obtain further information or if in doubt about the required eyesight standards please check with Drivers Medical Group, DVLA, Swansea SA99 1TU or telephone 0870 600 0301.

An applicant (or existing licence holder) failing to meet epilepsy, diabetes or eyesight regulations must be refused by law.

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 recommended medical guidelines in the following situations:

- Within 6 weeks of: myocardial infarction, an episode of unstable angina, CABG or coronary angioplasty.
- Angina, heart failure or cardiac arrhythmia which remain uncontrolled.
- Implanted cardiac defibrillator.
- Hypertension where the blood pressure is persistently 180 systolic or more and/or 100 diastolic or more.

- A stroke or TIA within the last 12 months.
- Unexplained loss of consciousness with liability to recurrence.
- Meniere's, or any other sudden and disabling vertigo within the past 1 year, with a liability to recurrence.
- Insuperable difficulty in communicating by telephone in an emergency.
- Major brain surgery and/or recent severe head injury with serious continuing after effects.
- Parkinson's disease, multiple sclerosis or other chronic neurological disorders with symptoms likely to affect safe driving.
- Psychotic illness, within the past 3 years.
- Serious psychiatric illness.
- If major psychotropic or neuroleptic medication is being taken.
- Alcohol and/or drug misuse within the past 1 year or alcohol and/or drug dependency in the past 3 years.
- Dementia.
- Any malignant condition, within the last 2 years, with a significant liability to metastasise (spread) to the brain.
- Any other serious medical condition likely to affect the safe driving of a medium/large goods or passenger carrying vehicle.

5. Tiredness: Sleep Disorders

Up to one fifth of accidents on motorways and other monotonous roads may be caused by drivers falling asleep at the wheel.

Many accidents are attributed to "driver inattention" but once vehicle faults, traffic offences, poor road or weather conditions, alcohol and specific medical causes are excluded, closer inspection suggests driver sleepiness may be the cause. Evidence for this includes the apparent failure to respond to traffic and road conditions generally and, in particular, the absence of signs of emergency braking.

Driver sleepiness may be caused by modern life styles preventing adequate rest. It may be made worse by shift working combined with the monotonous nature of certain types of driving. Alertness fluctuates naturally throughout the day. Driving between 2am and 7am increases the risk of a sleep related accident. Most people also tend to be less alert during the mid-afternoon or after a heavy meal. All drivers need to address these problems responsibly. However, some medical conditions may cause excessive sleepiness. These will greatly increase any normal tendency to sleepiness.

The most common medical cause is **OBSTRUCTIVE SLEEP APNOEA SYNDROME (OSA)**. This condition occurs most commonly, but not exclusively, in overweight individuals, particularly those with a large neck size. Partners often complain about the snoring and notice that sufferers seem to have irregular breathing during sleep. Sufferers of OSA rarely wake from sleep feeling fully refreshed and tend to fall asleep easily when relaxing.

OSA is one of the few medical conditions that has been shown to increase significantly the risk of traffic accidents. However, once diagnosed, there is very effective treatment available, normally through specialist centres. The greatest danger is prior to diagnosis, when the significance of the symptoms is not appreciated. A road traffic accident may be the first clear indication of the condition. All drivers, especially professional drivers, and doctors need to be much more aware of the risks of sleepiness from this treatable cause.

To obtain further information on DVLA Group 2 medical standards of fitness to drive, please refer to the DVLA's publication 'At a Glance Guide to the Current Medical Standards of Fitness to Drive' at www.dvla.gov.uk/medical/ataglance or 0870 600 0301.

MEDICAL EXAMINATION REPORT

Guidance Notes for the Doctor for completing the report

Before completing this form, please read information and useful notes (pages 2 and 3).

It may be helpful to consult DVLA's 'At A Glance Guide' (to the Current Medical Standards of Fitness to Drive). This is available for download at www.dvla.gov.uk/medical/ataglance.

Doctors may enquire in writing, or may speak to one of the medical advisers during office hours, to seek advice about a particular driver or about fitness to drive in general. After hours there is an answer phone.

Further help may be obtained by telephoning 01792 761119 (medical professionals only) and asking to speak to one of the Medical Advisers. Alternatively, enquiries can also be sent to medadviser@dvla.gsi.gov.uk, or to:

The Medical Adviser
Drivers Medical Group
DVLA
Longview Road
Morrison
SWANSEA SA99 1TU

DVLA will need to know the applicant's full name, address and date of birth.

Applicants who may be symptom-free at the time of the examination should be advised that if, in the future, they develop symptoms of a conditions which could affect safe driving they must inform the Licensing Department at Basingstoke and Deane Borough Council.

It is the duty of the licence holder or licence applicant to notify DVLA of any medical condition which may affect safe driving. If there are circumstances where the licence holder cannot, or will not, do so, the General Medical Council has issued clear guidelines to Doctors as to the appropriate action. The guidance is reproduced on Page 4 of the 'At A Glance' guide.

- The Medical Examination Report should be completed with reference to the applicant's medical history.
- Please answer **all** questions
- Please undertake a full examination of the patient. **This should include urine screening for Glucose.**
- Please make sure that you have printed the applicant's name and date of birth on each page before submitting this form



**Basingstoke
and Deane**

MEDICAL EXAMINATION REPORT

To be completed by the Doctor (please use black ink)

- Please answer **all** questions

Please give patient's weight and height

weight (kg/st)

height (cms/ft)

Please give details of smoking habits, if any

Please give number of alcohol units taken each week

Is the urine sample positive for Glucose?

Yes

No

(please tick appropriate box)

Details of specialist (s)/
consultants, including
address

1	2	3

Speciality

Date last seen

**Current medication
including exact dosage
and reason for each
treatment**

Date when first licensed to drive a car

and/or taxi/private hire vehicle

1 Vision (please see Eyesight notes on page 2)

Please tick ✓ the appropriate box(es)

YES

NO

1. Is the visual acuity **at least** 6/9 in the better eye and at least 6/12 in the other?
(corrective lenses may be worn) as measured with the full size 6m snellen chart

2. Do corrective lenses have to be worn to achieve this standard?

If **YES**, is the:-

(a) uncorrected acuity at least 3/60 in the right eye?

(b) uncorrected acuity at least 3/60 in the left eye?

(3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)

(c) correction well tolerated?

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart.

Please convert any 3 metre readings to the 6 metre equivalent.

Uncorrected

Corrected (if applicable)

Right

Left

Right

Left

4. **Is there a defect in his/her binocular field of vision** (central and/or peripheral)?

5. Is there diplopia? (controlled or uncontrolled)?

6. Does the applicant have any other ophthalmic condition?

If **YES** to 4, 5 or 6, please give details in **Section 7** and enclose any relevant visual field charts or hospital letters.

Applicant's name

DOB

Applicant's address

2 Nervous System

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has the applicant had any form of epileptic attack? | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) If YES , please give date of last attack | | |
| (b) If treated, please give date when treatment ceased | | |
| Is the applicant currently on anti-epileptic medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please complete current medication on page 5 of this form. | | |
| <hr/> | | |
| 2. Is there a history of blackout or impaired consciousness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please give date(s) and details in Section 7 | | |
| <hr/> | | |
| 3. Does the applicant suffer from narcolepsy/cataplexy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please give details in Section 7 | | |
| <hr/> | | |
| 4. Is there a history of, or evidence of, any of the conditions listed at a-h below? | YES | NO |
| If NO , go to Section 3 . | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please tick the relevant box(es) and give dates and full details at Section 7 . | | |
| (a) Stroke/TIA <i>please delete as appropriate</i> | <input type="checkbox"/> | |
| (b) Sudden and disabling dizziness/vertigo within the last year with a liability to recur | <input type="checkbox"/> | |
| (c) Subarachnoid haemorrhage | <input type="checkbox"/> | |
| (d) Serious head injury within the last 10 years | <input type="checkbox"/> | |
| (e) Brain tumour, either benign or malignant, primary or secondary | <input type="checkbox"/> | |
| (f) Other brain surgery | <input type="checkbox"/> | |
| (g) Chronic neurological disorders eg Parkinson's disease, Multiple Sclerosis | <input type="checkbox"/> | |
| (h) Dementia or cognitive impairment | <input type="checkbox"/> | |

3 Diabetes Mellitus

- | | | |
|--|--------------------------|--------------------------|
| 1. Does the applicant have diabetes mellitus? | YES | NO |
| If NO , please proceed to Section 4 . | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please answer the following questions. | | |
| <hr/> | | |
| 2. Is the diabetes managed by:- | | |
| (a) Insulin? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please give date started on insulin | | |
| (b) Oral hypoglycaemic agents and diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please complete current medication on the appropriate section on the front of this form | | |
| (c) Diet only? | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 3. Does the patient test blood glucose at least twice every day? | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 4. Is there evidence of:- | | |
| (a) Loss of visual field? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Diminished/Absent awareness of hypoglycaemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 5. Has there been laser treatment for retinopathy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES , please give date(s) of treatment | | |
| <hr/> | | |
| 6. Is there a history of hypoglycaemia during waking hours in the last 12 months requiring assistance from a third party? | <input type="checkbox"/> | <input type="checkbox"/> |

If **YES** to any of 4-6 above, please give details in **Section 7**.

Applicant's name

DOB

4 Psychiatric Illness

Is there a history of, or evidence of, any of the conditions listed at 1-6 below? YES NO

If **NO**, please go to **Section 5**

If **YES**, please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7**.

NB. If applicant remains under specialist clinic(s) ensure details are completed at the top of page 1. **YES**

- | | | |
|----|---|--------------------------|
| 1. | Significant psychiatric disorder within the past 6 months | <input type="checkbox"/> |
| 2. | A psychotic illness within the past 3 years, including psychotic depression | <input type="checkbox"/> |
| 3. | Persistent alcohol misuse in the past 12 months | <input type="checkbox"/> |
| 4. | Alcohol dependency in the past 3 years | <input type="checkbox"/> |
| 5. | Persistent drug misuse in the past 12 months | <input type="checkbox"/> |
| 6. | Drug dependency in the past 3 years | <input type="checkbox"/> |

N.B. Please enclose relevant hospital notes with reference to this condition.

5 Cardiac

Please follow the instructions in all Sections (5A-5G) giving details as required at Section 7 and enclose hospital notes relevant to this condition.

NB. If applicant remains under specialist cardiac clinic(s) ensure details are completed at the top of page 5 and Sections 5F and 5G.

5A Coronary Artery Disease

Is there a history of, or evidence of, coronary artery disease? YES NO

If **NO**, proceed to **Section 5B**

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

- | | | | |
|----|--|--------------------------|--------------------------|
| 1. | Myocardial Infarction?
If YES , please give date(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Coronary artery by-pass graft?
If YES , please give date(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Coronary Angioplasty (with or without stent)?
If YES , please give date(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Has the applicant suffered from Angina?
If YES , please give the date of the last attack | <input type="checkbox"/> | <input type="checkbox"/> |

Please proceed to next Section 5B

Applicant's name

DOB

5B Cardiac Arrhythmia

	YES	NO
Is there a history of, or evidence of, cardiac arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>
If NO , proceed to Section 5C		
If YES , please answer all questions below and give details at Section 7 of the form.		
1. Has the applicant had a significant documented disturbance of cardiac rhythm within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has a cardiac defibrillator device been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has a pacemaker been implanted?	<input type="checkbox"/>	<input type="checkbox"/>
If YES :-		
(a) Has the pacemaker been implanted for at least 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Since implantation, is the patient now symptom free from this condition?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Does the applicant attend a pacemaker clinic regularly?	<input type="checkbox"/>	<input type="checkbox"/>

Please proceed to next Section 5C

5C Peripheral Arterial Disease

1. Is there a history or evidence of ANY of the following:	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
If YES , please tick ✓ ALL relevant boxes below, and give details at Section 7 of the form.		
PERIPHERAL ARTERIAL DISEASE	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
AORTIC ANEURYSM, IF YES:		
(a) Site of Aneurysm: Thoracic <input type="checkbox"/> Abdominal <input type="checkbox"/>		
(b) Has it been repaired successfully:	<input type="checkbox"/>	<input type="checkbox"/>
(c) Is the transverse diameter more than 5cms:	<input type="checkbox"/>	<input type="checkbox"/>
DISSECTION OF THE AORTA, IF YES:		
(a) Has it been repaired successfully:	<input type="checkbox"/>	<input type="checkbox"/>

Please proceed to next Section 5D

5D Valvular/Congenital Heart Disease

	YES	NO
Is there a history of, or evidence, of valvular/congenital heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
If NO , proceed to Section 5E		
If YES , please answer all questions below and give details at Section 7 of the form.		
1. Is there a history of congenital heart disorder?	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there a history of heart valve disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there any history of embolism? (not pulmonary embolism)	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the applicant currently have significant symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has there been any progression since the last licence application? (if relevant)	<input type="checkbox"/>	<input type="checkbox"/>

Please proceed to next Section 5E

Applicant's name DOB

5E **Cardiomyopathy**

Does the applicant have a history of ANY of the following conditions:	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>
(a) A history of, or evidence of heart failure?		
(b) Established cardiomyopathy?		
(c) A heart or heart/lung transplant?		

If YES to any part of the above, please give full details in Section 7 of the form. If no, proceed to next Section 5F.

5F **Cardiac Investigations**

	YES	NO
This section must be completed for all applicants		
1. Has a resting ECG been undertaken?	<input type="checkbox"/>	<input type="checkbox"/>
If YES , does it show:-		
(a) pathological Q waves?	<input type="checkbox"/>	<input type="checkbox"/>
(b) left bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
(c) right bundle branch block?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
2. Has an exercise ECG been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7		
<i>Sight/copy of the exercise test result/report (if done in the last 3 years) would be useful</i>		
<hr/>		
3. Has an echocardiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7		
<i>Sight/copy of the echocardiogram result/report would be useful</i>		
<hr/>		
4. Has a coronary angiogram been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7		
<i>Sight/copy of the angiogram result/report would be useful</i>		
<hr/>		
5. Has a 24 hour ECG tape been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7		
<i>Sight/copy of the 24 hour tape result/report would be useful</i>		
<hr/>		
6. Has a myocardial perfusion imaging scan been undertaken (or planned)?	<input type="checkbox"/>	<input type="checkbox"/>
If YES , please give date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> and give details in Section 7		
<i>Sight/copy of the scan result/report would be useful</i>		

Please proceed to Section 5G

5G **Blood Pressure**

	YES	NO
This section must be completed for all applicants		
1. Is today's resting systolic pressure 180mm Hg or greater?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
2. Is today's resting diastolic pressure 100mm Hg or greater?	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
3. Is the applicant on anti-hypertensive treatment?	<input type="checkbox"/>	<input type="checkbox"/>
If YES , please complete current medication on page 5 of this form.		
If YES, to any of the above, please supply today's reading and three previous readings and dates.		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Applicant's name **DOB**

6 General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details in Section 7.

1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle? YES NO

2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? YES NO

If **YES**, please give dates and diagnosis and state whether there is current evidence of dissemination

4. Is the applicant profoundly deaf? YES NO
 If **YES**, is he/she able to communicate in the event of an emergency by speech or by using a device, eg a MINICOM/text phone? YES NO

4. Is there a history of either renal or hepatic failure? YES NO

5. Does the applicant have sleep apnoea syndrome? YES NO

If **YES**, please supply details

(a) Date of diagnosis

(b) Is it controlled successfully? YES NO

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

(d) Please state period of control

6. Is there any other **Medical Condition**, causing excessive daytime sleepiness? YES NO

If **YES**, please supply details

(a) Diagnosis

(b) Date of diagnosis

(c) Is it controlled successfully? YES NO

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

(e) Please state period of control

7. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? YES NO

8. In the last three years has the applicant been prescribed any medication for the treatment of anxiety, depression, other psychiatric disease, heart disease, or high blood pressure? YES NO

If **YES**, please provide details of the medication, including **dosage, the reason for each treatment and the period treatment was required.** (If further space is required please use Section 7.)

Applicant's name

DOB

CERTIFICATE

To be completed by the Doctor carrying out the examination

8 Declaration

I hereby certify that I have today examined the above named Applicant and that:

- the Applicant is registered at this medical practice
- the Applicant's medical notes were consulted whilst I carried out the medical
- to the best of my knowledge and belief, the answers to the foregoing questions are true and correct.

Name
Address
Telephone
E-mail address

Surgery Stamp

--

Signature of Medical Practitioner

--

Date

--

Please forward this completed report to:

The Licensing Team, Basingstoke and Deane Borough Council, Civic Offices, London Road, Basingstoke, Hampshire, RG21 4AH
If you have any queries please contact the Licensing Team at the above address or telephone: 01256 845374 Fax: 01256 845200 E-mail: licensing@basingstoke.gov.uk

For Office Use Only

Declaration of Council's Medical Adviser

Date Forwarded:

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Case Officer:

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Date Declaration Received:

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FIT

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UNFIT

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Follow up Action Required:

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