



Medical examination report for a Group 2 (lorry or bus) licence

D4

**If this form is not fully completed we will return it to you
and your application will be delayed.**

For information about completing the form read the leaflet INF4D.
This is also available at www.gov.uk/reapply-driving-licence-medical-condition

Your details (applicant)

Name _____

Full address _____

Daytime phone number _____ Date of birth _____

Email address _____

Date first licensed to drive a lorry (if known) _____ Date first licensed to drive a bus (if known) _____

Your doctor's details

Doctor's name _____

Full address _____

Phone number _____ Email address _____

**You must sign and date the declaration on page 8 when the doctor and/or
optician has completed the report.**

**This report is valid for 4 months from the date the
doctor and/or optician or optometrist signs it.
Please return it together with your application form.**

Examining doctor's details – to be completed by the doctor carrying out the examination.

Doctor's name _____

Full address _____

Phone number _____ Email address _____

GMC registration number

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**You must sign and date this form in Section 10. All black outlined boxes
MUST be answered. Please make sure all sections of the form have been completed.
The form will be returned to you if you don't do this.**



Driver & Vehicle
Licensing
Agency

Medical examination report

Vision assessment

To be filled in by a doctor or optician/optometrist

If correction is needed to meet the eyesight standard for driving, all questions must be answered. If correction is not needed, questions 5 and 6 can be ignored.

D4

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

Snellen ☐ Snellen expressed as a decimal ☐
LogMAR ☐

2. Please state the visual acuity of each eye (see INF4D).
Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

Uncorrected

Corrected

(using prescription worn for driving)

R	L	R	L
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3. 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**
☐ ☐

4. Were corrective lenses worn to meet this standard? **Yes** **No**
☐ ☐

If **Yes**, glasses ☐ contact lenses ☐ both together ☐

5. If **glasses** (not contact lenses) are worn for driving, is the corrective power greater than plus (+)8 dioptries in any meridian of either lens? **Yes** **No**
☐ ☐

6. If correction is worn for driving, is it well tolerated? **Yes** **No**
If **No**, please give full details in the box provided ☐ ☐

7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? **Yes** **No**
☐ ☐

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

8. Is there diplopia? **Yes** **No**
☐ ☐

(a) If **Yes**, is it controlled? ☐ ☐

If **Yes**, please give full details in the box provided

9. Does the applicant on questioning, report symptoms of intolerance to glare and/or impaired contrast sensitivity and/or impaired twilight vision that impairs their ability to drive? **Yes** **No**
☐ ☐

10. Does the applicant have any other ophthalmic condition? **Yes** **No**
☐ ☐

If **Yes** to any of questions 7-10, please give full details in the box provided.

Details/additional information

You must sign and date this section.

Name of examining doctor/optician (print)

Signature of examining doctor/optician

Date of signature

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

Please provide your GOC or GMC number

--	--	--	--	--	--	--	--	--	--

Doctor/optometrist/optician's stamp

Applicant's full name

Date of birth

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

Please do not detach this page



Medical examination report

Medical assessment

Must be filled in by a doctor

- Please check the applicant's identity before you proceed.
- Please ensure you fully examine the applicant and take the applicant's history.

D4

1 Neurological disorders

Please tick ✓ the appropriate box(es)

Is there a history of, or evidence of **any** neurological disorder? Yes ☐ No ☐

If **No**, go to section 2

If **Yes**, please answer **all** the questions below, give details in section 6, page 6 and enclose relevant hospital notes.

1. Has the applicant had any form of seizure? Yes ☐ No ☐
- (a) Has the applicant had more than one attack? Yes ☐ No ☐
- (b) Please give date of first and last attack
- First attack
- Last attack
- (c) Is the applicant currently on anti-epileptic medication? Yes ☐ No ☐
- If **Yes**, please fill in current medication in **section 8, page 7**
- (d) If no longer treated, please give date when treatment ended
- (e) Has the applicant had a brain scan? Yes ☐ No ☐
- If **Yes**, please give details in **section 6, page 6**
- (f) Has the applicant had an EEG? Yes ☐ No ☐
- If **Yes** to any of above, please supply reports if available.
2. Stroke or TIA? Yes ☐ No ☐
- If **Yes**, please give date
- Has there been a **FULL** recovery? Yes ☐ No ☐
- Has a carotid ultrasound been undertaken? Yes ☐ No ☐
- If **Yes**, was the carotid artery stenosis >50% in either carotid artery? Yes ☐ No ☐
3. Sudden and disabling dizziness/vertigo within the last year with a liability to recur? Yes ☐ No ☐
4. Subarachnoid haemorrhage? Yes ☐ No ☐
5. Serious traumatic brain injury within the last 10 years? Yes ☐ No ☐
6. Any form of brain tumour? Yes ☐ No ☐
7. Other brain surgery or abnormality? Yes ☐ No ☐
8. Chronic neurological disorders? Yes ☐ No ☐
9. Parkinson's disease? Yes ☐ No ☐
10. Is there a history of blackout or impaired consciousness within the last 5 years? Yes ☐ No ☐
11. Does the applicant suffer from narcolepsy? Yes ☐ No ☐

2 Diabetes mellitus

Does the applicant have diabetes mellitus? Yes ☐ No ☐

If **No**, go to section 3, page 4

If **Yes**, please answer **all** the questions below.

1. Is the diabetes managed by: Yes ☐ No ☐
- (a) Insulin? Yes ☐ No ☐
- If **Yes**, please give date started on insulin
- (b) If treated with insulin, are there at least 3 continuous months of blood glucose readings stored on a memory meter(s)? Yes ☐ No ☐
- If **No**, please give details in **section 6, page 6**
- (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)-(e), please fill in current medication in **section 8, page 7**
- (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. Is there any evidence of impaired 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 dates and details in **section 6**
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** to any of 4-5 above, please give details in **section 6, page 6**
6. Has there been laser treatment or intra-vitreal treatment for retinopathy? Yes ☐ No ☐
- If **Yes**, please give date(s) of treatment.
-

Applicant's full name

Date of birth

3

Cardiac

a

Coronary artery disease

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

YesNo

If **No**, go to **section 3b**

If **Yes**, please answer **all** questions below and give details at **section 6** of the form and enclose relevant hospital notes.

1. Has the applicant suffered from angina?

YesNo

If **Yes**, please give the date of the last known attack

DDMMYY
2. Acute coronary syndrome including myocardial infarction?

YesNo

If **Yes**, please give date

DDMMYY
3. Coronary angioplasty (PCI)?

YesNo

If **Yes**, please give date of most recent intervention

DDMMYY
4. Coronary artery bypass graft surgery?

YesNo

If **Yes**, please give date

DDMMYY
5. If **Yes** to any of the above, are there any physical health problems (e.g. mobility/arthritis, COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT?

YesNo

b

Cardiac arrhythmia

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

YesNo

If **No**, go to **section 3c**

If **Yes**, please answer **all** questions below and give details in **section 6, page 6** and enclose relevant hospital notes.

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

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

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

YesNo
4. Has a pacemaker been implanted?

YesNo

If **Yes**:

(a) Please give date of implantation

DDMMYY

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

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

c

Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history of, or evidence of, peripheral arterial disease (excluding Buerger's disease), aortic aneurysm/dissection?

YesNo

If **No**, go to **section 3d**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6**, and enclose relevant hospital notes.

1. Peripheral arterial disease (excluding Buerger's disease)

YesNo
2. Does the applicant have claudication?

YesNo

If **Yes**, how long in minutes can the applicant walk at a brisk pace before being symptom-limited?

Please give details
3. Aortic aneurysm?

YesNo

If **Yes**:

(a) Site of aneurysm: Thoracic Abdominal

(b) Has it been repaired successfully?

(c) Is the transverse diameter **currently** > 5.5 cm?

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

DDMMYY
4. Dissection of the aorta repaired successfully?

YesNo

If **Yes**, please provide copies of all reports to include those dealing with any surgical treatment.
5. Is there a history of Marfan's disease?

YesNo

If **Yes**, please provide relevant hospital notes

d

Valvular/congenital heart disease

Is there a history of, or evidence of, valvular/congenital heart disease?

YesNo

If **No**, go to **section 3e**

If **Yes**, please answer **all** questions below and give details in **section 6 page 6** and enclose relevant hospital notes.

1. Is there a history of congenital heart disease?

YesNo
2. Is there a history of heart valve disease?

YesNo
3. Is there a history of aortic stenosis?

YesNo

If **Yes**, please provide relevant reports
4. Is there any history of embolism? (**not** pulmonary embolism)

YesNo
5. Does the applicant currently have significant symptoms?

YesNo
6. Has there been any progression since the last licence application? (if relevant)

YesNo

e

Cardiac other

Is there a history of, or evidence of heart failure?

YesNo

If No, go to section 3f

If Yes, please answer all questions and enclose relevant hospital notes.

YesNo

1. Established cardiomyopathy?

YesNo

2. Has a left ventricular assist device (LVAD) been implanted?

YesNo

3. A heart or heart/lung transplant?

YesNo

4. Untreated atrial myxoma?

YesNo

f

Cardiac channelopathies

Is there a history of, or evidence of either of the following conditions?

YesNo

If No, go to section 3g

1. Brugada syndrome?

YesNo

2. Long QT syndrome?

YesNo

If Yes to either, please give details in section 6 and enclose relevant hospital notes.

g

Blood pressure

If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's best resting blood pressure reading

2. Is the applicant on anti-hypertensive treatment?

YesNo

If Yes, please provide three previous readings with dates if available

DDMMYY

DDMMYY

DDMMYY

3. Is there a history of malignant hypertension?

YesNo

If Yes, please provide details in section 6 (including date of diagnosis and any treatment etc)

h

Cardiac investigations

Have any cardiac investigations been undertaken or planned?

YesNo

If No, go to section 4

If Yes, please answer questions 1-6

YesNo

1. Has a resting ECG been undertaken?

YesNo

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, page 6.

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

YesNo

If Yes, please give date

DDMMYY

and give details in section 6, page 6

Please provide relevant reports if available

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

YesNo

(a) If Yes, please give date

DDMMYY

and give details in section 6, page 6.

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

Please provide relevant reports if available

4. Has a coronary angiogram been undertaken (or planned)?

YesNo

If Yes, please give date

DDMMYY

and give details in section 6, page 6.

Please provide relevant reports if available

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

YesNo

If Yes, please give date

DDMMYY

and give details in section 6, page 6.

Please provide relevant reports if available

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

YesNo

If Yes, please give date

DDMMYY

and give details in section 6, page 6.

Please provide relevant reports if available

4

Psychiatric illness

Is there a history of, or evidence of, psychiatric illness, drug/alcohol misuse within the last 3 years?

YesNo

If No, go to section 5

If Yes, please answer all questions below

1. Significant psychiatric disorder within the past 6 months?

YesNo

2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression?

YesNo

3. Dementia or cognitive impairment?

YesNo

4. Persistent alcohol misuse in the past 12 months?

YesNo

5. Alcohol dependence in the past 3 years?

YesNo

6. Persistent drug misuse in the past 12 months?

YesNo

7. Drug dependence in the past 3 years

YesNo

If 'Yes' to any questions above, please provide full details in section 6, page 6, including dates, period of stability and where appropriate consumption and frequency of use.

Applicant's full name

Date of birth

DDMMYY

5

General

All questions must be answered. If Yes to any, give full details in section 6 and enclose relevant hospital notes.

1. Is there a history of, or evidence of, Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?

YesNo

If Yes, please give diagnosis

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 6.

b) Please answer questions (i) – (vi) for all sleep conditions

(i) Date of diagnosis

D

D

M

M

Y

Y

YesNo

(ii) Is it controlled successfully?

(iii) If Yes, please state treatment

YesNo

(iv) Is applicant compliant with treatment?

(v) Please state period of control

(vi) Date of last review

D

D

M

M

Y

Y

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

YesNo

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

YesNo

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving?

YesNo

5. Is the applicant profoundly deaf?

YesNo

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?

6. Does the applicant have a history of liver disease of any origin?

YesNo

If Yes, please give details in section 6

7. Is there a history of renal failure?

YesNo

If Yes, please give details in section 6

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

YesNo

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

YesNo

If Yes, please provide details of medication and symptoms in section 6

10. Does the applicant have any other medical condition that could affect safe driving?

YesNo

If Yes, please provide details in section 6

6

Further details

Please forward copies of relevant hospital notes. Please do not send any notes not related to fitness to drive.

Applicant's full name

Date of birth

D

D

M

M

Y

Y

6

7

Consultants' details

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

Consultant in
Name
Address

Date of last appointment

D

D

M

M

Y

Y

Consultant in
Name
Address

Date of last appointment

D

D

M

M

Y

Y

Consultant in
Name
Address

Date of last appointment

D

D

M

M

Y

Y

8

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:	

Applicant's full name

9

Additional information

Patient's weight (kg)	
Height (cms)	
Details of smoking habits, if any	
Number of alcohol units taken each week	

10

Examining doctor's signature and stamp

To be completed by the doctor carrying out the examination. Please ensure all sections of the form have been completed. The form will be returned to you if you don't do this.

I confirm that this report was completed by me at examination. I also confirm that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside of the UK.

Signature of practitioner

Date of signature

D

D

M

M

Y

Y

Doctor's stamp

Date of birth

D

D

M

M

Y

Y

The applicant must complete 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:

inform my doctors about the outcome of my case

Yes
☐

No
☐

release reports to my doctors

☐

☐

Checklist

■ Have you signed and dated the declaration?

Yes
☐

■ Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?

☐

**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.**

General Practitioner (Doctor) Declaration

PATIENT DETAILS	
NAME:	
ADDRESS:	
DATE OF BIRTH:	

I CERTIFY THAT: I am a General Practitioner with full access to the applicant's NHS records at the time of examination

I CERTIFY THAT: I have reviewed all the applicant's medical history and have today examined the named applicant, and I consider that the applicant:

Has MET the DVLA Group 2 Medical Standard ☐

Has NOT MET the DVLA Group 2 Medical Standard ☐

I declare that the answers to all questions are true to the best of my knowledge and belief. I understand that it is an offence for the person completing this form to make a false statement or omit relevant details.

Name:

Signature:

Date:

Doctor Stamp:

