Driver & Vehicle Licensing Agency

Confidential medical information

CG1

CG1
Rev Jul 22

PART A: ABOUT YOU

Please complete this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title _____ Full name _____

Full address _____

_____

Postcode _____ Date of birth _____

NHS number _____ Driver number _____
(If known)

Mobile number _____ Home number _____
(Optional) *(Optional)*

Email _____
(Optional)

PART B: HEALTHCARE PROFESSIONAL DETAILS

Please provide the details of the GP OR consultant you have seen for this condition
IMPORTANT: You must provide the full name and address of your GP and/or consultant. The form will be returned to you resulting in delays.

GP DETAILS

Full name _____

Surgery _____

Full address _____

_____

Postcode _____ Phone number _____

Email _____
(If known)

Date last seen by GP for this condition _____

CONSULTANT DETAILS

Title _____ Full name _____

Department _____

Full Hospital address _____

_____

_____

Postcode _____ Phone number _____

Email _____
(If known)

Date last seen by consultant for this condition _____

Driver & Vehicle Licensing Agency

CG1
Rev Feb 19

Questionnaire to assess your Medical Fitness to Drive

If you are unsure of the answers, we advise you to discuss the form with your Doctor.

1. Please give the name of your medical condition or conditions.

2. Please give the name and dosage (the amount you take) of all the current medication taken by you or enclose a copy of your repeat prescription counterfoil. Continue overleaf if necessary.

Name of Medication	Dosage	Reason for Taking

3. Please supply the dates below of any phone, video or face to face consultations for this condition?

	Doctor	Consultant
Date of last contact		
Date of next contact		

4. Does the medication make you drowsy or confused when driving? Yes ☐ No ☐

5. Do you need help from another person with your day to day living? Yes ☐ No ☐

   If YES, please give details of how they help you.

6. In the past 12 months have you regularly misused alcohol? Yes ☐ No ☐

7. In the past 12 months have you taken illicit drugs? Yes ☐ No ☐

CG1

8. Do you need to drive a vehicle fitted with special controls or automatic transmission? (If No, do not answer 8a/b) Yes ☐ No ☐

   a) Have you told us before that you need special controls or automatic transmission? (If Yes, please answer 8b) Yes ☐ No ☐

   b) Since your last licence was issued have you had any additional controls fitted to your vehicle? Yes ☐ No ☐

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Applicant's authorisation

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and 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 and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.
- These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.
- Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

This section must NOT be altered in any way.

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory 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 correspond with healthcare professionals via electronic channels (fax or email) **Yes** ☐ **No** ☐

If you would like to be contacted about your application by email or text message (SMS), please tick the appropriate boxes (below). If not, DVLA will continue to contact you by post.

I authorise a representative of the Secretary of State to contact me via Email or SMS text in relation to this application (Please Tick): **Email** ☐ **Yes** ☐ **No** **SMS (Text)** ☐ **Yes** ☐ **No**

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Note: please complete and return all pages of this medical questionnaire and authorisation form. If you do not give us all the information we need including the full name, address, and telephone number of your GP/Consultant then there will be a delay with your case.

Please use the contact details below to return your completed medical questionnaire to the **Drivers Medical Group**

By Post:

Drivers Medical Group,
DVLA,
Swansea.
SA99 1DF

By Fax:

0300 083 0083

Electronically – Email:

eftd@dvla.gov.uk

Please keep this page for future reference.