



If you are unsure of the answers, it would be advisable to discuss the form with your Mental Health Doctor or Nurse

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

2. Are you currently taking any medication for this condition? Yes No

3. Please give the name and dosage(the amount you take) of all the current medication prescribed to you for the above conditions:

Name of Medication and Dosage	Reason for taking

4. In the past 3 years, have you required treatment for:

Alcohol dependence? Yes No

Drug dependence? Yes No

Has this included treatment of supervised detoxification? Yes No

If Yes, please give the most recent date of treatment:

DD	MM	YY

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

6. In the past 12 months have you misused illicit drugs? Yes No

If **YES**, please give brief details: _____

7. In the last 12 months, have you required admission or referral to a hospital or a clinic for psychiatric treatment? Yes No

If **YES**, please give the dates and details: _____

NAME:	DOB:	REF:
-------	------	------

DRIVER NUMBER:

8. In the past 12 months, have you suffered any fits or blackouts Yes No

If YES, please give the dates:

DD	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>

9. Please supply the date you were last seen for the condition declared at Question 1.

Seen by Consultant:

DD	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>

Seen by CPN:

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Seen by GP:

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

NAME:	DOB:	REF:
DRIVER NUMBER:		



Applicants declaration

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 release information relevant to the medical assessment of your fitness.
- 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.

All data held by DVLA is used for internal evaluation of the quality of our services.

This section must NOT be altered in any way.

Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition relevant to my fitness to drive, to the Secretary of State’s medical adviser.

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, orthoptists, 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 Doctor(s) of the outcome of my case Yes No

Release my medical information, and any other relevant information, to my doctor(s) by postal or electronic (fax or email) channels 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

NAME:	DOB:	REF:
-------	------	------

DRIVER NUMBER:



Note: please fill in and return all pages (1-4) of this medical questionnaire and consent/declaration. 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 filled in medical questionnaire to the Drivers Medical Group.

By Post

Drivers Medical Group
DVLA
Swansea
SA99 1DF

By fax

0300 083 0083

Please keep this page (5) for future reference.

Find out about DVLA's online services

Go to: www.gov.uk/browse/driving

