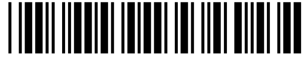
Driver & Vehicle Licensing Agency

Confidential medical information



BP1V

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 and Consultant you have seen for this condition
IMPORTANT: You must provide their full name and address, or the form will be returned to you, delaying your application.

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

Medical questionnaire – blood pressure – vocational

BP1V
Rev Oct 16

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

1. Do you suffer from hypertension or have problems with your blood pressure control that requires medication? Yes ☐ No ☐

2. Please give the date treatment started. DATE ☐☐☐

3. Does your medication cause dizziness or make you drowsy or confused throughout the day? Yes ☐ No ☐

4. When was the last time you saw your GP to have your blood pressure checked? DATE ☐☐☐

5. Please provide 3 blood pressure readings, taken on 3 separate days within the last 6 months at your GP surgery. You may need to ask your surgery for this information. Please note home readings are not acceptable.

Date			
Reading	/		

Date			
Reading	/		

Date			
Reading	/		

Please sign and date the enclosed Authorisation and Declaration

Driver & Vehicle Licensing Agency

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 medical professionals by 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**

Driver & Vehicle Licensing Agency

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

Email: eftd@dvla.gov.uk

Please keep this page for future reference

Find out about **DVLA's online services**

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