



**IMPORTANT:** Please answer the questions in **BLOCK CAPITAL** letters using **BLACK INK**.
   
 Failure to provide full information for yourself, GP or consultant may result in your case being delayed.

**PART A: About you**

**Current driving licence details**

**Title:** \_\_\_\_\_ **Full name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_
   
**Address:** \_\_\_\_\_
   
**Postcode:** \_\_\_\_\_
   
**Email:** \_\_\_\_\_ **Contact number:** \_\_\_\_\_

**Change of details**

If you have changed your contact information (address, name, email or contact number) since we last corresponded with you, please provide the **NEW** details in the box below.


**PART B: Healthcare professional for your condition**

**GP details**

**GP name:** 
  
**Surgery name:** 
  
**Address:** 
  

  
**Town:** 
  
**Postcode:** 
  
**Contact number:** 
  
**Email:** 
  
**Date last seen for this condition:**

**Consultant details**

**Consultant name:** 
  
**Speciality:**  **Department:** 
  
**Hospital name:** 
  
**Address:** 
  

  
**Town:** 
  
**Postcode:** 
  
**Contact number:** 
  
**Email:** 
  
**Date last seen for this condition:**



# Medical questionnaire – cancer – vocational

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

## 1. Your condition

1.1 | Please give details of your diagnosis/condition.

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1.2 | Please give the date of diagnosis.

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

1.3 | Have you been advised by your healthcare professional that you are currently unfit to drive Group 1 and/or Group 2 vehicles?

Yes	No
<input type="text"/>	<input type="text"/>

If yes, please indicate

Grp 1	Grp 2
<input type="text"/>	<input type="text"/>

1.4 | Do you have problems with fatigue or weakness that are likely to affect safe driving?

Yes	No
<input type="text"/>	<input type="text"/>

1.5 | Have you undergone treatment for your cancer?

Yes	No
<input type="text"/>	<input type="text"/>

1.6 | As a result of your condition, have you ever suffered from any of the following:

1.7 | Sudden disabling giddiness/dizziness?

Yes	No
<input type="text"/>	<input type="text"/>

**DATE OF LAST EPISODE**

If yes, please give details:

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

1.8 | Fainting, blackout or loss of consciousness?

Yes	No
<input type="text"/>	<input type="text"/>

**DATE OF LAST EPISODE**

If yes, please give details:

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

1.9 | Any form of seizure?

Yes	No
<input type="text"/>	<input type="text"/>

If yes, please give:

	AWAKE		
	DD	MM	YY
Date of first seizure	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of last seizure	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

# C1V

## 2. Your medication

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2.1 | Please give the name and dosage of all the current medication prescribed to you.

NAME OF MEDICATION	DOSAGE	REASON FOR TAKING

2.2 | Does any of your medication affect your ability to drive safely? Yes  No

## 3. Your appointments

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

	DOCTOR			CONSULTANT		
	DD	MM	YY	DD	MM	YY
Date of last contact	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of next contact	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## 4. Special controls

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4.1 | As a result of your medical condition, do you have to drive a vehicle with automatic gears? Yes  No

4.2 | As a result of your medical condition, do you have to drive a vehicle with special controls? Yes  No

If yes, please indicate what controls you need and complete the “special modifications” form on the next page

# C1V

## 4.3 | Select any modifications that you need to drive a lorry or bus

Modified transmission (10)	<input type="checkbox"/>	Modified clutch (15)	<input type="checkbox"/>	Modified braking system (20)	<input type="checkbox"/>
Modified accelerator system (25)	<input type="checkbox"/>	Pedal adaptations and pedal safeguards (31)	<input type="checkbox"/>	Combined service brake and accelerator systems (32)	<input type="checkbox"/>
Combined service brake, accelerator and steering systems (33)	<input type="checkbox"/>	Modified control layouts (35)	<input type="checkbox"/>	Modified steering (40)	<input type="checkbox"/>
Modified rear view mirror (42)	<input type="checkbox"/>	Modified driver seat (43)	<input type="checkbox"/>		

## 4.4 | Select any modifications that you need to drive a motorcycle, moped or tricycle

Single operated brake (44.01)	<input type="checkbox"/>	Adapted front wheel brake (44.02)	<input type="checkbox"/>	Adapted rear wheel brake (44.03)	<input type="checkbox"/>
Adjusted accelerator (44.04)	<input type="checkbox"/>	Adjusted manual transmission and clutch (44.05)	<input type="checkbox"/>	Adjusted rear view mirror (44.06)	<input type="checkbox"/>
Adjusted commands (for example, light or indicators) (44.07)	<input type="checkbox"/>	Seat height (allows the driver to have 2 feet on the surface at once and balance the wheel when stopping /standing) (44.08)	<input type="checkbox"/>	Adapted footrest (44.11)	<input type="checkbox"/>
Adapted hand grip (44.12)	<input type="checkbox"/>	Motorcycle with sidecar only (45)	<input type="checkbox"/>		

If you have ticked any of the above you will need to return your driving licence with this completed form.



**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](http://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 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



**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

**Electronically – Email:**

[eftd@dvla.gov.uk](mailto: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](http://www.gov.uk/browse/driving)

