Driver & Vehicle Licensing Agency

SL1

SL1
Rev Apr 24

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:	

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Medical questionnaire – sleep disorders

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Rev Nov 23

1. Has your condition **ever** been linked with excessive sleepiness having, or likely to have an adverse effect on driving?

Yes ☐ No ☐

If no, DO NOT complete the rest of the form

Narcolepsy and/or Cataplexy

*Please **only** complete this section if you have been diagnosed with Narcolepsy and/or Cataplexy.*

2. Have you been diagnosed with narcolepsy or cataplexy?

Yes ☐ No ☐

If no, go to Q3

a) If yes, how long has it been controlled?

Less than 3mths ☐ 3mths-12mths ☐

12mths-7yrs ☐ More than 7yrs ☐

Please go to Q7

Mild Obstructive Sleep Apnoea or other sleep condition(s)

*Please **only** complete this section if you have been diagnosed with mild OSAS or another sleep condition.*

3. Have you been diagnosed with Mild Obstructive Sleep Apnoea Syndrome (OSAS)?
Mild OSAS is a diagnosis with an AHI <15

Yes ☐ No ☐ Not known ☐

4. When did your symptoms start?

Less than 3mths ☐ More than 3mths ☐

5. Are you symptoms controlled?

Yes ☐ No ☐

6. Do you agree to attend regular reviews and to follow medical advice regarding any necessary treatment?

Regular reviews should occur at least once every 3 years with a healthcare professional such as your GP, consultant or specialist. A review can be in the form of telephone call, video call or in-person consultations.

Yes ☐ No ☐

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7. Have you had any contact (any phone, video or face to face consultation) with your healthcare professional about your condition in the last 12 months?

Yes ☐ No ☐

8. Who should we contact if we need to investigate your condition further?

GP ☐ Consultant ☐

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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 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**

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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

Electronically – Email:

eftd@dvla.gov.uk

Please keep this page for future reference