



DEFIB1

**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 – defibrillator (ICD)

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

1. Has your Implantable Cardioverter Defibrillator (ICD) been fitted solely for primary prevention reasons?

Solely for primary prevention means you have not yet suffered from a disturbance of heart rhythm but are considered at risk due to family history or an underlying heart condition.

Yes

☐

→ Go to 2

No

☐

- a) If no, please tell us the date your ICD was fitted.

DD

MM

YY

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2. Has your ICD delivered shock therapy (whether caused by the device or arrhythmia)?

Yes

☐

No

☐

→ Go to declaration

- a) If yes, please tell us the date your ICD delivered shock therapy.

DD

MM

YY

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- b) Was the shock caused by a serious heart rhythm problem, such as a dangerously fast or irregular heartbeat, and did it result in you being unable to function as usual following the shock?

Yes

☐

No

☐

- c) Was the shock due to atrial fibrillation (arrhythmia) or a programming issue?

Yes

☐

No

☐

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## Declaration

**You must confirm you've read and understood the following information.**

As a driver with an Implantable Cardioverter Defibrillator (ICD) implanted, I agree to:

- undergo regular check-ups for my ICD as advised by my healthcare professional
- follow the advice of my healthcare professional for the treatment of my heart condition
- notify DVLA if my ICD delivers “shock” therapy (unless this has occurred during clinical testing) or any sudden attacks of disabling dizziness/fainting or blackouts

Put ‘X’ in the box if you agree with the following statement.

**“I have a defibrillator implanted and I agree to comply with the above conditions if I am issued with a car or motorcycle (group 1) driving licence”**

☐



### **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. If not, DVLA will continue to contact you by post. Email ☐ SMS (text) ☐

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of DVLA, please tick the appropriate boxes. If not, you'll be contacted by post.

Email ☐ SMS (text) ☐



Driver & Vehicle  
Licensing  
Agency

**Note:** there will be a delay with your case if you do not give us all the information we need, including the full name, address and telephone number of your healthcare professional.

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 email:**

[eftd@dvla.gov.uk](mailto:eftd@dvla.gov.uk)

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We invest in people Gold

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