Driver & Vehicle Licensing Agency

C 1

C1
Rev May 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:

Driver & Vehicle Licensing Agency

Medical questionnaire – cancer

C1
Rev Dec 18

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

1. Your condition

1.1 Please give details of your diagnosis/condition.

1.2 Please give the date of diagnosis. **DD** **MM** **YY**

1.3 Have you been advised by your healthcare professional that you are currently unfit to drive? Yes / No

1.4 Do you have problems with fatigue or weakness that are likely to affect safe driving? Yes / No

1.5 Have you undergone treatment for your cancer? Yes / No

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

If yes, please give details:

DATE OF LAST EPISODE **DD** **MM** **YY**

1.8 Fainting, blackout or loss of consciousness? Yes / No

If yes, please give details:

DATE OF LAST EPISODE **DD** **MM** **YY**

1.9 Any form of seizure? Yes / No

If yes, please give:

	AWAKE			ASLEEP		
	DD	**MM**	**YY**	**DD**	**MM**	**YY**
Date of first seizure						
Date of last seizure						

C1

2. Your medication

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

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						
Date of next contact						

4. Special controls

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

C1

4.3 | Select any modifications that you need to drive a car

Modified transmission *(10)* ☐	Modified clutch *(15)* ☐	Modified braking system *(20)* ☐
Modified accelerator system *(25)* ☐	Pedal adaptations and pedal safeguards *(31)* ☐	Combined service brake and accelerator systems *(32)* ☐
Combined service brake, accelerator and steering systems *(33)* ☐	Modified control layouts *(35)* ☐	Modified steering *(40)* ☐
Modified rear view mirror *(42)* ☐	Modified driver seat *(43)* ☐	

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

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

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

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 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

Please keep this page for future reference.