



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:

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Contact number:

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Email: _____

Date last seen for this condition:

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Consultant details

Consultant name: _____

Speciality: _____ **Department:** _____

Hospital name: _____

Address: _____

Town: _____

Postcode:

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Contact number:

--	--	--	--	--	--	--	--	--	--	--

Email: _____

Date last seen for this condition:

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Medical questionnaire – substance misuse – vocational

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

1. Within the last 3 years have you used any of the following drugs? Yes No
(Please indicate which drugs and provide the requested information)

	Yes	Date first used		Date last used		How much?	How often?
		MM	YY	MM	YY	quantity used	per wk/month
a) Heroin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) Morphine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If yes, is the morphine prescribed? Yes No

c) Non prescribed methadone or buprenorphine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d) Cocaine/Crack Cocaine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e) Methamphetamine/ Crystal Meth	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f) Benzodiazepines (e.g. Diazepam/ Temazepam etc)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If yes, are the benzodiazepines prescribed? Yes No

	Yes	Date first used		Date last used		How much?	How often?
		MM	YY	MM	YY	quantity used	per wk/month
g) Cannabis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If yes, is the cannabis prescribed? Yes No

h) Amphetamine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
i) Ecstasy (MDMA)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
j) LSD	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
k) Ketamine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
l) Other drugs, Illicit/street, legal/illegal or solvents	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If please, tell us the name of drug: _____

DG1V

2. In the past 3 years, have you been on a drug treatment programme for opioid drug dependence? Yes No
(for example, buprenorphine, methadone, naltrexone)

If yes, please give the date treatment started, and ended (if applicable)

START DATE		END DATE	
MM	YY	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

- a) If yes to Q2 please tell us the name and address of your healthcare professional at the clinic.

Name: _____

Address: _____

- b) Date of last contact

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

3. As a result of your drug use have you had any seizures within the last 3 years? Yes No

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

- a) Please give the date of the most recent episode.

If yes, please tell us the name and address of the healthcare professional we should contact for further information.

Name: _____

Address: _____

- b) Date of last contact

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

Driver declaration:

I declare that I have checked the details given and that to the best of my knowledge and belief, they are correct.

Please be aware that incomplete answers may result in delays.

Signature: _____

Today's date:
(DD/MM/YY) _____

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.



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We invest in people Gold

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