Driver & Vehicle Licensing Agency

DIZ1V

DIZ1V
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 – dizziness – vocational

DIZ1V
Rev Nov 15

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

1. In the past 12 months, have you experienced any episodes of severe dizziness? ***If no, please go to Question 5*** Yes ☐ No ☐

	FIRST			LAST			OTHER		
	DD	MM	YY	DD	MM	YY	DD	MM	YY
If yes, please give dates:									

2. If known please give the cause

a) Labyrinthitis Yes ☐ No ☐
b) Meniere's Disease Yes ☐ No ☐
c) Vertigo Yes ☐ No ☐
d) Migraine Yes ☐ No ☐
e) Other, please give details _____

_____

3. Are the attacks disabling or would they be likely to affect your driving if they were to occur when you are driving? Yes ☐ No ☐

a) Do you always have warning of the attacks? Yes ☐ No ☐

b) If yes to question 3a, would you have sufficient time to stop your vehicle safely? Yes ☐ No ☐

4. Have you or are you receiving treatment to control the attacks? Yes ☐ No ☐

If yes, please give details of treatment for this condition _____

_____

_____

_____

5. Have any of the episodes ever caused a blackout? Yes ☐ No ☐

	DD	**MM**	**YY**
If yes, please provide date of blackout			

6. 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						

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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. 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)** ☐

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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.