Driver & Vehicle Licensing Agency

SL1

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 personal 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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Sleep self-declaration

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

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**

2 What sleep-related condition have you been diagnosed with? (Please tick all that apply)

Narcolepsy/Cataplexy ☐

Idiopathic Hypersomnia ☐

Obstructive Sleep Apnoea (OSA)/ Obstructive Sleep Apnoea Syndrome (OSAS) (with excessive sleepiness likely to have adverse effect on driving) ☐

Any other condition that causes excessive sleepiness **(Please tell us the condition below)** ☐

_____

3 If **diagnosed with** obstructive sleep apnoea/obstructive sleep apnoea syndrome, please indicate the severity:
Mild OSAS is a diagnosis with an Apnoea Hypopnoea Index (AHI) <15. Moderate/Severe is a diagnosis with an AHI >15.

Mild ☐ Moderate/Severe ☐

Don't know the severity ☐

4 When did the symptoms for your sleep condition start?

DD	MM	YY

5 Are your symptoms controlled?

Yes ☐ **No** ☐ **If 'No', go to Q6**

5a If '**Yes'**, when did your symptoms become controlled?

DD	MM	YY

5b If you are not receiving treatment, how has your condition been controlled?

_____

_____

6 Do you agree to attend regular reviews and to follow medical advice regarding any necessary treatment?
Regular reviews with a healthcare professional such as your GP, consultant or specialist should be undertaken as recommended by your sleep service.

Yes ☐ No ☐

7 Please tell us the details of your sleep centre/specialist consultant for any further investigations:

Name: _____

Department: _____

Hospital: _____

_____

_____

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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 the 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 via electronic channels (email) **Yes** ☐ **No** ☐

If you would like to be contacted about your application by email or text message (SMS) by a healthcare professional acting on behalf of the DVLA, please tick the appropriate boxes below.
If no boxes are ticked, you will be contacted by post.

Email ☐ **SMS (Text)** ☐

If you would like to be contacted about your application by email or text message (SMS), please tick the appropriate boxes. If no boxes are ticked, DVLA will continue to contact you by post.

Email ☐ **SMS (Text)** ☐