



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: _____



V1 Vision self declaration

If you are unsure of how to answer these questions, you can discuss the form with your healthcare professional or optician/optometrist.

If your vision condition has been caused by one of the following health conditions, you will need to fill in the medical questionnaire stated below:

- Brain tumour- BT1
- Head injury- B1
- Stroke/TIA- STR1
- Myasthenia Gravis- CN1

You can download these forms from **www.gov.uk/driving-medical-conditions**

You cannot currently use our online service to tell us if you have multiple health conditions.

Important- Regular eyesight tests will give reassurance that you still meet the legal eyesight standards for driving (see www.gov.uk/driving-eyesight-rules). If you don't meet the vision standards and are involved in an accident, you could be prosecuted and your motor insurance will be invalid.

Question 1

Eyesight standards

You must not have been told by a healthcare professional or optician/optometrist that your eyesight is currently worse than 6/12 (decimal 0.5) on the Snellen scale (letter chart you read at the opticians). You must be able to read a number plate from 20 metres, which is the length of around 5 parked cars (with or without glasses or corrective lenses if needed).

a) Do you meet the eyesight standard for driving?

Yes, without
glasses or
corrective lenses

☐

Yes, with
glasses or
corrective lenses

☐

No

☐

Question 2

Do you have vision in both eyes? (Do not include long or short sightedness).

Yes

☐

→ go to Q3

No

☐

a) If 'No' and you have vision in one eye (monocular) please tell us which eye

Left eye only

☐

Right eye only

☐

b) How long have you had vision in one eye?

Since birth or childhood

☐

As a result of a health condition, accident or injury

☐

Question 2 continued

c) Vision in one eye (monocular) declaration.

As you only have vision in one eye, please confirm that you have adapted to vision in one eye and have not been advised otherwise by your healthcare professional or optician/optometrist.

Yes, I have been advised by my healthcare professional or optician/optometrist that I have fully adapted to having vision in only one eye.

☐

No, I have not been advised by my healthcare professional or optician/optometrist that I have fully adapted to having vision in only one eye.

☐

Question 3

Have you been told by your healthcare professional or optician/optometrist that you have a problem with your field of vision?

(Your field of vision is the total area you can see when looking straight ahead, including side vision.)

Yes ☐

No ☐ → go to Q4

b) If 'Yes', is your visual field problem caused solely by an eye condition?

Yes ☐ → go to Q4

No ☐

c) If 'No', is your visual problem caused by any of the following?

Brain tumour ☐

Head injury ☐

Stroke ☐

Other ☐

If 'Other' please tell us the details

Question 4

Do you have glaucoma?

Yes ☐

No ☐ → go to Q5

a) If 'Yes' which eye(s) are affected by glaucoma?

Both eyes ☐

Left eye ☐

Right eye ☐

Question 5

Do you have retinitis pigmentosa?

Yes ☐

No ☐ → go to Q6

a) If 'Yes' which eye(s) are affected by retinitis pigmentosa?

Both eyes ☐

Left eye ☐

Right eye ☐

Question 6

Have you had laser treatment?

(Do not include any treatment for long/short sightedness or cataracts)

Yes

☐

No

☐

→go to Q7

- a) If 'Yes' please tell us the date of your first treatment

Left eye

Right eye

- b) If 'Yes' please tell us the date of your last treatment

Left eye

Right eye

Question 7

Do you have blepharospasm?

Yes

☐

No

☐

→go to Q8

- a) If 'Yes' which eye(s) are affected by blepharospasm?

Both eyes

☐

Left eye

☐

Right eye

☐

- b) Have you had any treatment for your blepharospasm? Yes

☐

No

☐

- c) Is your healthcare professional or optician/optometrist satisfied that your blepharospasm is adequately controlled? Yes

☐

No

☐

Question 8

Do you have night blindness (nyctalopia)?

Yes

☐

No

☐

→go to Q9

- a) If 'Yes' which eye(s) are affected by night blindness:

Both eyes

☐

Left eye

☐

Right eye

☐

Question 9

Do you have double vision (diplopia)?

Yes

☐

No

☐

→go to Q10

- a) If 'Yes', is it controlled?

Yes

☐

No

☐

- b) If 'No', has your double vision been the same for 6 months or more?

Yes

☐

No

☐

Question 9 continued

c) Double vision declaration

It can take 3 months or more for you to adapt to driving with a patch, prism, frosted glasses, or lenses because:

- your ability to judge distances may be affected
- you may not be aware of objects each side of you

You should not drive until you have been advised by your healthcare professional or optician/optometrist that you have fully adapted to wearing a patch, prism, frosted glasses, or lenses.

Please put an 'X' in the box to confirm that you have read and understood the information above ☐

Signature: _____

DD MM YY

Question 10

Do you have another vision condition that you have not already told us about?

Yes ☐

No ☐ → go to Q11

a) If 'Yes' please tell us the condition(s) and which eye(s) affected below:

Question 11

Have you had any contact (by telephone, video, or face to face), with your healthcare professional or optician/optometrist about your vision condition in the last 12 months?

Yes ☐

No ☐

a) If 'Yes' please tell us the date of this contact

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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 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) ☐



Driver & Vehicle
Licensing
Agency

Note: please complete and return all pages of this medical questionnaire and authorisation form. If you do not give us all the information, we need including the full name, address, and telephone number of your GP/Consultant then there will be a delay with your case.

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

Electronically – Email:

eftd@dvla.gov.uk

Please keep this page for future reference.



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