Driver & Vehicle Licensing Agency

DIZ1V

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:

Dizziness – self declaration

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

1 Have you experienced any episode(s) of dizziness in the last 12 months?

Yes ☐ No ☐ **If 'No' go to Q3**

2 If **'Yes'**, please tell us the dates of the dizziness episode(s):

	DD	MM	YY
First			

	DD	MM	YY
Last two			

3 Has a cause for your dizziness been diagnosed?

Yes ☐ No ☐ **If 'No' go to Q4**

3a If '**Yes'**, please tell us the cause and date of diagnosis: (Please put an '**X**' in the box that applies)

				DD	MM	YY
3b	Labyrinthitis	Yes	☐			
3c	Ménière's Disease	Yes	☐			
3d	Vertigo	Yes	☐			
3e	Migraine	Yes	☐			
3f	Other	Yes	☐			

3g If 'Other', please give the cause and date of diagnosis:

4 Were any of the dizziness episodes severe and/or disabling?

Yes ☐ No ☐

5 Would the dizziness episodes make driving unsafe?

Yes ☐ No ☐

6 Do you always have a warning of a dizziness episode? (for example room spinning, vomiting, headaches)

Yes ☐ No ☐

7 Would this warning give sufficient time to stop your vehicle safely, if you were driving? Yes ☐ No ☐

8 Has the dizziness caused a blackout in the last 12 months?

Yes ☐ No ☐

8a If '**Yes**', please tell us the date of the blackout:

DD	MM	YY

8b Please tell us the details of the blackout episode(s):

9 Please tell us the date of your last and next appointment with your healthcare professional who is treating the dizziness episode(s):

	DD	MM	YY		DD	MM	YY
Last contact				Next contact			

Driver & Vehicle Licensing Agency

Rev July 22

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
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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.

Keep up to date with our latest news and services at:

gov.uk/dvla