



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: _____
Specialty: _____ Department: _____
Hospital name: _____
Address: _____
Town: _____
Postcode: _____
Contact number: _____
Email: _____
Date last seen for this condition: _____

General self declaration

If you are unsure of the answers, we advise you to discuss the form with your healthcare professional. Please answer ALL questions, or your case will be delayed.

1. Please tell us the name of your medical condition(s) _____

2. Please tell us the approximate date of diagnosis.

Month	Year

3. Was your condition caused by an illness? Yes ☐ No ☐

If **'Yes'**, please tell us the full details: _____

a) Was your condition caused by an accident? Yes ☐ No ☐

If **'Yes'**, please tell us the full details: _____

b) Was your condition caused by a head injury? Yes ☐ No ☐

*If **'Yes'**, please visit www.gov.uk/health-conditions-and-driving to download and complete a B1 medical questionnaire and send it to DVLA. Alternatively, upon receipt of this questionnaire we will send you a B1 questionnaire to fill in.*

G1

4. Does your condition affect your driving? Yes ☐ No ☐

If **'Yes'**, please give full details: _____

5. Has your doctor advised that you are currently fit to drive? Yes ☐ No ☐ No advice ☐

If **'No'** what advice have you been given? _____

- 6 Have you had a driving assessment? Yes ☐ No ☐

If **'Yes'**, please enclose a copy of the report

Healthcare professional

7. Who was the last healthcare professional you saw for this condition (any phone, video, face to face consultation)?

GP ☐ Consultant ☐ Nurse specialist at hospital clinic ☐

- a) Please tell us the date of your last contact with that healthcare professional
- | DD | MM | YY |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Special controls

8. As a result of your health condition, do you have any problems with your limbs that affect your ability to control your vehicle safely?

Yes ☐

No ☐ If **'No'** go to Q8c

- a) As a result of your health condition, do you have to drive a vehicle with special controls?

Yes ☐ If **'Yes'** go to Q8b

No ☐

G1

Special Controls

b) If yes, please tell us of any modifications that you need to drive a:			If yes, please tell us of any modifications that you need to drive a:
	Car	Bus or Lorry	Motorcycle, Moped or Tricycle
• transmission (10)	☐	☐	• single operated brake (44.01) ☐
• clutch (15)	☐	☐	• adapted front wheel brake (44.02) ☐
• braking system (20)	☐	☐	• adapted rear wheel brake (44.03) ☐
• accelerator system (25)	☐	☐	• adjusted accelerator (44.04) ☐
• pedal adaptations and safeguards (31)	☐	☐	• adjusted manual transmission and clutch (44.05) ☐
• combined service brake and accelerator systems (32)	☐	☐	• adjusted rear view mirror (44.06) ☐
• combined service brake, accelerator and steering systems (33)	☐	☐	• adjusted commands (light, indicators etc.) (44.07) ☐
• control layouts (35)	☐	☐	• seat height (allows the driver to have 2 feet on the surface at once and balance the wheel when stopping/standing) (44.08) ☐
• steering (40)	☐	☐	• adapted footrest (44.11) ☐
• rear view mirror (42)	☐	☐	• adapted hand grip (44.12) ☐
• driver seat (43)	☐	☐	• motorcycle with sidecar only (45) ☐

c) As a result of your health condition, have you been told that you can only drive a vehicle with automatic gears?

Do not mark 'Yes' if you drive a vehicle with automatic gears by choice.

Yes, car only ☐ Yes, lorry or bus ☐ No ☐



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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