

# Medical examination report for a Group 2 (bus or lorry) licence

For advice on completing this form, read the leaflet INF4D available at www.gov.uk/reapply-driving-licence-medical-condition Please use black ink when completing this report.



Medical professionals must complete all green

sections on this report.

Applicants must complete all grey sections on this report which includes the section below, applicants full name and date of birth at the end of each page and the declaration on page 8.

the declaration on page o.	Important information for doctors carrying
Important: This report is only valid for	out examinations.
4 months from date of examination.	Before you fill in this report, you must check the applicant's
Name	identity and decide if you are able to complete the Vision
	assessment on page 2. If you are unable to do this, you must inform the applicant that they will need to ask an
	optician or optometrist to complete the Vision assessment.
Date of birth	Examining doctor
Address	Name
	Company or practice address
Postcode	
Contact number	
Email address	
	Postcode
	Company or practice contact number
Date first licensed to drive a bus or lorry	
DDMMYY	Company or practice email address
If you do not want to receive survey invitations by email from	
DVLA, please tick box	
Your doctor's details (only complete if different	
from examining doctor's details)	GMC registration number
GP's name	
	I can confirm that I have checked the applicant's documents to prove their identity.
Practice address	
	Signature of examining doctor
	Applicant's weight (kg) Applicant's height (cm)
Postcode	Number of alcohol units consumed each week
Contact number	Units per week
	Critic per week
Email address	
	Does the applicant smoke? Yes No
	Do you have access to the
	applicant's full medical record?



Important: Signatures must be provided at the end of this report

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### Medical examination report

## Vision assessment



1.	Please confirm ( ) the scale you are using to express the applicant's visual acuities.  Snellen Snellen expressed as a decimal LogMAR	5. Does the applicant on questioning report symptoms of any of the following that impairs their ability to drive?  Yes No
2.	The visual acuity standard for Group 2 driving	Please indicate below and give full details in Q7 below.
	is at least 6/7.5 in one eye and at least 6/60 in the other.	(a) Intolerance to glare and/or
	(a) Please provide uncorrected visual acuities	(b) Impaired contrast sensitivity and/or (c) Impaired twilight vision
	for each eye.	
	R L Voc No	6. Does the applicant have any other ophthalmic condition?
	(b) Are corrective lenses worn for driving?  If No, go to Q3.	If Yes, please give full details in Q7 below.
	If Yes, please provide the visual acuities using the correction worn for driving.	7. Details or additional information
	R	
	(c) What kind of corrective lenses are worn to meet this standard?	
	Glasses Contact lenses Both together	
	(d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens?	
	(e) If correction is worn for driving,  Yes No	
	is it well tolerated?  If No, please give full details in Q7.	Name of examining doctor or optician undertaking
	g. a. a. a. a. a. a. a.	vision assessment
3.	Is there a history of any medical condition that may affect the applicant's binocular	
	field of vision (central and/or peripheral)?	Loopfirm that this vaport was completed by me at
	If Yes, please give full details below.	I confirm that this report was completed by me at examination and the applicant's history has been taken
		into consideration.  Signature of examining doctor or optician
	If formal visual field testing is considered necessary,  DVLA will commission this at a later date.	
		Date of signature
4.	Is there diplopia?	Please provide your GOC or GMC number
	(a) Is it controlled?	Destar entematrist or entision's stars
	Please indicate below and give full details in Q7.	Doctor, optometrist or optician's stamp
	Patch or Glasses Other	
	glasses with with/without (if other please frosted glass prism provide details)	
Ар	plicant's full name	Date of birth DDMMYY
	Please do not	detach this page



### Medical examination report

## **Medical assessment**

Must be filled in by a doctor

**D4** 

1	Neurological disorders		2	Diabetes ı	mellitus		
Is the discourt of the discour	ase tick ✓ the appropriate boxes ere a history or evidence of any neurological rder (see conditions in questions 1 to 11 below)?  o, go to section 2, Diabetes mellitus es, please answer all questions below and enclose relevious notes.	No /ant	If No If Yes 1.	o, go to sections, please answ Is the diabete	have diabetes mellitus? on 3, Cardiac ver all questions below. s managed by:	Yes	
1.	Has the applicant had any form of seizure?  (a) Has the applicant had more than one attack?  (b) If Yes, please give date of first and last attack.  First attack  Last attack  Last attack  (c) Is the applicant currently on anti-epileptic medication?  If Yes, please fill in the medication section 8, page 6.  (d) If no longer treated, when did treatment end?  (e) Has the applicant had a brain scan?  If Yes, please give details in section 9, page 7.  (f) Has the applicant had an EEG?	No		of blood g on a mem If No, plea (c) Other inject (d) A Sulphon (e) Oral hypog If Yes to al the medica (f) Diet only?	give date ulin.  at least 3 continuous months lucose readings stored ory meter(s)?  se give details in section 9, particular treatments?  ylurea or a Glinide?  glycaemic agents and diet?  ny of (a) to (e), please fill in ation section 8, page 6.	ge 7.	No
2.	If you have answered Yes to any of above, you must supply medical reports.  Has the applicant had an episode(s) of non-epileptic attack disorder?  (a) If Yes, please give date of most recent episode.  (b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving?	No .		<ul><li>(b) Does the a to driving the start o 2 hours who carbohydr when driving (d) Does the a understand</li></ul>	ice every day? applicant test at times relevant (no more than 2 hours before f the first journey and every hile driving)? applicant keep fast-acting ate within easy reach ng? applicant have a clear ding of diabetes and the precautions for safe driving?		
3.	Stroke or TIA?  If Yes, give date.	No .		Is there full av	vareness	Yes	No
4.	<ul> <li>(a) Has there been a full recovery?</li> <li>(b) Has a carotid ultra sound been undertaken?</li> <li>(c) If Yes, was the carotid artery stenosis &gt;50% in either carotid artery?</li> <li>(d) Is there a history of multiple strokes/TIAs?</li> <li>Sudden and disabling dizziness or vertigo within the last year with a liability to recur?</li> </ul>			in the last 12 assistance of	ory of hypoglycaemia months requiring the another person? give details and dates below.	Yes	No
5.	Subarachnoid haemorrhage?					V	NI-
6.	Serious traumatic brain injury within the last 10 years?				sual field? ripheral neuropathy, sufficient	Yes	No
7.	Any form of brain tumour?			•	imb function for safe driving?		Ш
8.	Other brain surgery or abnormality?			If Yes, please	give details in section 9, page	7.	
9.	Chronic neurological disorders?				en laser treatment or eatment for retinopathy?	Yes	No
10.	Parkinson's disease?			If Yes, please	give		ш
11.	Blackout or impaired consciousness within the last 10 years?			most recent do of treatment.	late DDMMY		
Ар	plicant's full name				Date of birth	МΥ	Y

3 Cardiac		c Peripheral arterial disease (excluding Buerger's disease)	
a Coronary artery disease		aortic aneurysm/dissection	
Is there a history or evidence of coronary artery disease?  If No, go to section 3b, Cardiac arrhythmia  If Yes, please answer all questions below and enclose relevant hospital notes.	Yes No	Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection?  If No, go to section 3d, Valvular/congenital heart If Yes, please answer all questions below and enclose relevant hospital notes.	Yes No  disease
1. Has the applicant suffered from angina?  If Yes, please give the date of the last known attack.	Yes No	Peripheral arterial disease?     (excluding Buerger's disease)	Yes No
2. Acute coronary syndrome including myocardial infarction?  If Yes, please give date.	Yes No	2. Does the applicant have claudication?  If Yes, would the applicant be able to undertake 9	Yes No
3. Coronary angioplasty (PCI)?  If Yes, please give date of most recent intervention.	Yes No	minutes of the standard Bruce Protocol ETT?  3. Aortic aneurysm?  If Yes:	Yes No
4. Coronary artery bypass graft surgery?  If Yes, please give date.	Yes No	<ul> <li>(a) Site of aneurysm: Thoracic Abdominal</li> <li>(b) Has it been repaired successfully?</li> <li>(c) Please provide latest transverse aortic</li> </ul>	
5. If Yes to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would mak the applicant unable to undertake 9 minutes of standard Bruce Protocol ETT? Please give deta	the	diameter measurement and date obtained using measurement and date boxes.	
		4. Dissection of the aorta repaired successfully?  If Yes, please provide copies of all reports including those dealing with any surgical treatment.	Yes No ent.
b Cardiac arrhythmia		<ol><li>Is there a history of Marfan's disease?</li><li>If Yes, please provide relevant hospital notes.</li></ol>	Yes No
Is there a history or evidence of cardiac arrhythmia?	Yes No	o. 13 there a mistery of Marian's discase:	Yes No
Is there a history or evidence of	se	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease	Yes No Yes No
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial disease of the sect	se elose	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?	
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial disease of the section of	se	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?  If No, go to section 3e, Cardiac other  If Yes, answer all questions below and provide relevant hospital notes.	
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial disease. If Yes, please answer all questions below and encrelevant hospital notes.  1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?  2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	se elose	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?  If No, go to section 3e, Cardiac other  If Yes, answer all questions below and provide relevant hospital notes.  1. Is there a history of congenital heart disease?	Yes No
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial disease. If Yes, please answer all questions below and encrelevant hospital notes.  1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?  2. Has the arrhythmia been controlled	se Slose Yes No	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?  If No, go to section 3e, Cardiac other  If Yes, answer all questions below and provide relevant hospital notes.  1. Is there a history of congenital heart disease?	Yes No Yes No
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial disease. If Yes, please answer all questions below and encrelevant hospital notes.  1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?  2. Has the arrhythmia been controlled satisfactorily for at least 3 months?  3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator	yes No Yes No	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?  If No, go to section 3e, Cardiac other  If Yes, answer all questions below and provide relevant hospital notes.  1. Is there a history of congenital heart disease?  2. Is there a history of heart valve disease?  Is there a history of aortic stenosis?  If Yes, please provide relevant reports (including echocardiogram).	Yes No Yes No Yes No
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial disease. If Yes, please answer all questions below and encrelevant hospital notes.  1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?  2. Has the arrhythmia been controlled satisfactorily for at least 3 months?  3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?  4. Has a pacemaker or a biventricular pacemaker/cardiac resynchronisation therapy pacemaker	Yes No Yes No Yes No	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?  If No, go to section 3e, Cardiac other  If Yes, answer all questions below and provide relevant hospital notes.  1. Is there a history of congenital heart disease?  2. Is there a history of heart valve disease?  If Yes, please provide relevant reports (including echocardiogram).  4. Is there any history of embolism?	Yes No Yes No Yes No Yes No
Is there a history or evidence of cardiac arrhythmia?  If No, go to section 3c, Peripheral arterial disease. If Yes, please answer all questions below and encrelevant hospital notes.  1. Has there been a significant disturbance of cardiac rhythm? (e.g. sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter or fibrillation, narrow or broad complex tachycardia) in the last 5 years?  2. Has the arrhythmia been controlled satisfactorily for at least 3 months?  3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted?  4. Has a pacemaker or a biventricular pacemaker/cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted?  If Yes:  (a) Please give date	Yes No Yes No Yes No	If Yes, please provide relevant hospital notes.  d Valvular/congenital heart disease  Is there a history or evidence of valvular or congenital heart disease?  If No, go to section 3e, Cardiac other If Yes, answer all questions below and provide relevant hospital notes.  1. Is there a history of congenital heart disease?  2. Is there a history of heart valve disease?  1. Is there a history of aortic stenosis? If Yes, please provide relevant reports (including echocardiogram).  4. Is there any history of embolism? (not pulmonary embolism)  5. Does the applicant currently have significant symptoms?	Yes No Yes No Yes No Yes No Yes No

e Cardiac other		boxes provided, give details in section 9, page 7 and provide relevant reports.
Is there a history or evidence of heart failure?  If No go to section 3f, Cardiac channelopathies  If Yes, please answer all questions and enclose relevant hospital notes.	Yes No	2. Has an exercise ECG been undertaken (or planned)?  3. Has an echocardiogram been undertaken Yes No
Please provide the NYHA class, if known.		(or planned)?
2. Established cardiomyopathy? If Yes, please give details in section 9, page 7.	Yes No	(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?
<b>3.</b> Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	Yes No	Has a coronary angiogram been undertaken Yes No (or planned)?
4. A heart or heart/lung transplant?	Yes No	5. Has a 24 hour ECG tape been undertaken Yes No
5. Untreated atrial myxoma?	Yes No	(or planned)?
f Cardiac channelopathies		6. Has a myocardial perfusion scan or stress echo study been undertaken (or planned)?
Is there a history or evidence of the following conditions?  If No, go to section 3g, Blood pressure	Yes No	DDMMYY
Brugada syndrome?	Yes No	7. Date last seen by a consultant specialist for any cardiac condition declared:
<ol><li>Long QT syndrome?</li><li>If Yes to either, please give details in section 9,</li></ol>	Yes No	4 Psychiatric illness
page 7 and enclose relevant hospital notes.		Is there a history or evidence of psychiatric Yes No illness within the last 3 years?  If No, go to section 5, Substance misuse
g Blood pressure		If Yes, please answer all questions below.
All questions must be answered.  If resting blood pressure is 180 mm/Hg systolic or and/or 100mm/Hg diastolic or more, please take a 2 readings at least 5 minutes apart and record the of the 3 readings in the box provided.  1. Please record today's best	further	<ol> <li>Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition.</li> <li>Psychosis or hypomania/mania within the past 12 months, including psychotic depression?</li> </ol>
resting blood pressure reading.  2. Is the applicant on anti-hypertensive treatment?	Yes No	Yes No 3. Dementia or cognitive impairment?
If Yes, please provide three previous readings with dates if available.		5 Substance misuse
	Y Y Y Y Y Y	Is there a history of drug/alcohol misuse or dependence?  If No, go to section 6, Sleep disorders  If Yes, please answer all questions below.
3. Is there a history of malignant hypertension? If Yes, please give details in section 9,	Yes No	1. Is there a history of alcohol dependence Yes No in the past 6 years?
page 7 (including date of diagnosis and any treating homeometrical contents of the contents of the page 7 (including date of diagnosis and any treating homeometrical contents of the contents		(a) Is it controlled? (b) Has the applicant undergone an alcohol detoxification programme?  If Yes, give date started:
Have any cardiac investigations been undertaken or planned?  If No, go to section 4, Psychiatric illness  If Yes, please answer questions 1 to 7.	Yes No	2. Persistent alcohol misuse in the past 3 years?  (a) Is it controlled?
<ul> <li>1. Has a resting ECG been undertaken? If Yes, does it show: <ul> <li>(a) pathological Q waves?</li> <li>(b) left bundle branch block?</li> <li>(c) right bundle branch block?</li> </ul> If Yes to (a), (b) or (c), please provide a copy of the relevant ECG report or comment in section 9</li> </ul>	Yes No	3. Persistent misuse of drugs or other substances Yes No in the past 6 years?  (a) If Yes, the type of substance misused?  (b) Is it controlled?  (c) Has the applicant undertaken an opiate treatment programme?  If Yes, give date started
Applicant's full name		Date of hirth

6	Sleep disorders	5. Does the applicant have a history  Yes No
1.	Is there a history or evidence of Obstructive Yes No Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness?  If No, go to section 7, Other medical conditions.	of liver disease of any origin?  If Yes, is this the result of alcohol misuse?  If Yes, please give details in section 9, page 7.
	If Yes, please give diagnosis and answer all questions below.	6. Is there a history of renal failure?  If Yes, please give details in section 9, page 7.
	a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:	7. Does the applicant have severe symptomatic Yes No respiratory disease causing chronic hypoxia?
	Mild (AHI <15)  Moderate (AHI 15 - 29)  Severe (AHI >29)  Not known  If another measurement other than AHI is used, it	8. Does any medication currently taken cause the applicant side effects that could affect safe driving?  If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.
	must be one that is recognised in clinical practice as equivalent to AHI. DVLA does not prescribe different measurements as this is a clinical issue. Please give details in section 9 page 7, Further details.	9. Does the applicant have any other medical Yes No condition that could affect safe driving?  If Yes, please provide details in section 9, page 7.
	b) Please answer questions (i) to (vi) for <b>all</b> sleep conditions.	8 Medication
	(i) Date of diagnosis: DDMMYYY (ii) Is it controlled successfully?  (iii) If Year places state treatment	Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).
	(iii) If Yes, please state treatment.	Medication Dosage
	Yes No	Reason for taking:
	(iv) Is applicant compliant with treatment? (v) Please state period of control:	Date started:
	years months  (vi) Date of last review.	Medication Dosage
2.	Is there a history or evidence of narcolepsy?	Reason for taking:  Date started:
7	Other medical conditions	Medication Dosage
7 1.	Is there currently any functional impairment Yes No that is likely to affect control of the vehicle?	Reason for taking:
2.	In there a history of branchagonia carainama	Date started:
۷.	or other malignant tumour with a significant liability to metastasise cerebrally?	Medication Dosage
3.	Is there any illness that may cause significant Yes No fatigue or cachexia that affects safe driving?	Reason for taking:  Date started:
4.	Is the applicant profoundly deaf?	D D M M T T
	If Yes, is the applicant able to communicate in the event of an emergency by speech or by using a device, e.g. a textphone?	Medication Dosage
		Reason for taking:  Date started:  D D M M Y Y
Apı	plicant's full name	Date of birth

9 Further details	10 Consultants' details
Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the	Please provide details of type of specialists or consultants, including address.
space below to provide any additional information.	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment.
	Consultant in
	Reason for attendance
	Name
	Address
	Date of last appointment:
	If more consultants seen give details on a separate sheet.
	11 Examining doctor's signature and stamp
	To be completed by the doctor carrying out the examination.
	Please make sure all sections of the form have been completed. The form will be returned to you if you do not do this.
	I confirm that this report was completed by me at examination and I have taken the applicant's history into account. I also confirm that I am currently GMC registered and licensed to practice in the UK or I am a doctor who is medically registered within the EU, if the report was completed outside the UK.
	Signature of examining doctor
	Date of signature
	Doctor's stamp
Applicant's full name	Date of birth DDMMYY

# The applicant must complete this page

### **Applicant's declaration**

You **must** fill in this section and **must not** alter it in any way.

Please read the following important information carefully then 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 or some form of practical assessment. If we do, the people involved will need your medical details to carry out an appropriate assessment. These may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only release information relevant to the medical assessment of your fitness to drive. Also, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more members of the Secretary of State's Honorary Medical Advisory Panels. Panel members must adhere strictly to the principle of confidentiality.

#### **Declaration**

I authorise my doctor and specialist to release reports and information about my condition which is relevant to my fitness to drive, to the Secretary of State's medical adviser.

I understand that the Secretary of State may disclose relevant medical information that is necessary to investigate my fitness to drive, to doctors, paramedical staff and 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:	
	No
inform my doctors about the outcome of my case	$\neg$
release reports	
to my doctor(s)	
Contact me about my application by:	
Yes I	No
email	
sms(text message)	
(Please note: DVLA will continue to contact you by post if you do not wish to be contacted by email or text.)	
Checklist	⁄es
<ul> <li>Have you signed and dated the declaration?</li> </ul>	
<ul> <li>Have you checked that the optician or doctor has filled in all parts of the report and</li> </ul>	es/
all relevant hospital notes have been enclosed?	
Important	
Important	
This report is valid for 4 months from the date the doctor, optician or optometrist signs it.	
This report is valid for 4 months from the date the doctor, optician or	
This report is valid for 4 months from the date the doctor, optician or optometrist signs it.  Please return it together with your	