FORM 3
(BLUE)

NEWARK AND SHERWOOD DISTRICT COUNCIL

Local Government (Miscellaneous Provisions) Act 1976
Medical Report for a Hackney Carriage/Private Hire
Vehicle Driver's Licence

NEWARK & SHERWOOD DISTRICT COUNCIL

This Certificate requires completing:

a. on the first application for a driver's licence;

b. on each renewal application following the 45th birthday until the driver attains 65;

c. annually for drivers aged 65 and over; and

d. on all other occasions when required by the Council.

This Certificate, which must be completed by the Council's Occupational Health Physician, is NOT issued free of charge as part of the National Health Service. Newark and Sherwood District Council accepts no liability to pay for it. Unless any other arrangements have been made for the payment of the fee, the applicant is to pay on the day. The fee is £60 and is non-refundable.

Applicants wishing to make an appointment with the Council's Occupational Health Physician should contact AC Medical Services, The Corner House, Rectory Road, Colwick, Nottingham, NG4 2DU. Book over the phone on 07802 850084 or at www.acmedical.co.uk/medicals/

Only in very exceptional circumstances may the medical be performed by any other physician, and only then, with the prior approval of the Business Manager. In these circumstances the Council reserves the right to request a further examination by the Occupational Health Physician, which would be at the applicants own expense.

Please note, if you need to wear prescription glasses to drive, you will be required to take your prescription with you to the medical examination.

The examination will be carried out in accordance with the recommendations of the Medical Commission on Accident prevention for group II (vocational) drivers; as laid down in the 'Medical Standards of Fitness To Drive' dated February 2008, which can be found on: www.dvla.gov.uk/at_a_glance/content.

Applicants should complete Parts A, C and D of this form prior to their appointment.

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A. THE APPLICANT

TITLE	Mr/Mrs./Miss	D.O.B.
SURNAME		
FORENAME(S)		
ADDRESS		

OCCUPATION _____

SIGNATURE OF APPLICANT _____

(To be signed in the presence of the Occupational Health Physician/General Practitioner)

Please give the name and address of the doctor (or group practice) that you may have been registered with over the last 12 months.

Names(s)	
Address	
Postcode	

B. TO BE COMPLETED BY THE OCCUPATIONAL HEALTH PHYSICIAN/GENERAL PRACTITIONER ONLY

Recommendation: I certify that I am Occupational Health Physician/the applicant's General Practitioner* and I have this day examined the applicant, who has signed this form in my presence and who in my opinion has/
has not* attained the medical standards as recommended by the Medical Commission on Accident Prevention for group II vocational drivers and is fit/unfit* to drive Hackney Carriages and Private Hire vehicles.

Occupational Health Physician/General Practitioner

Signature . . . . . .Date. . . . . .

Recommended Date of Next Examination .....

* Delete as applicable.

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C. THE APPLICANT

TITLE	Mr/Mrs./Miss	D.O.B.
SURNAME		
FORENAME(S)		
ADDRESS		

OCCUPATION _____

SIGNATURE OF APPLICANT _____

(To be signed in the presence of the Occupational Health Physician/General Practitioner)

Please give the name and address of the doctor (or group practice) that you may have been registered with over the last 12 months.

Names(s) Address Postcode	

NOTE:

This form is totally confidential to the Occupational Health Physician/General Practitioner. It will be kept by him/her as a personal and confidential record and no private medical details will be disclosed. You are however responsible for the accuracy of your statements.

D. THIS SECTION TO BE COMPLETED BY APPLICANT:

Please answer every question and, where appropriate, enter the word 'none'.

Do not use ticks or dashes.

If the answers to questions 1 or 2 are 'NO', **please give brief details in the space provided:**

1. Are you in good health? YES/NO _____

2. Is your vision good in both eyes - taking into account glasses/contact lenses, (if worn)? YES/NO _____

If the answers to any of questions 3 to 17 are 'YES', **please give brief details, including dates,** in the space provided:

3. Are you now receiving any treatment? YES/NO _____
4. Are you disabled in any way? YES/NO _____
5. Are you a registered disabled person? YES/NO _____
6. Any heart trouble (including angina, high blood pressure)? YES/NO _____
7. Any chest trouble (chronic bronchitis, asthma, tuberculosis)? YES/NO _____
8. Any stomach trouble (ulcer, colitis)? YES/NO _____
9. Any back trouble, rheumatism or arthritis or joint problems? YES/NO _____
10. Any skin trouble (dermatitis, eczema, psoriasis)? YES/NO _____
11. Any 'blackouts', fainting attacks, fits or epilepsy? YES/NO _____
12. Any nerve trouble (anxiety, depression, debility)? YES/NO _____
13. Any other chronic disease or injury? YES/NO _____
14. Do you have a Diabetic condition? YES/NO _____
15. Any impairment of hearing? YES/NO _____
16. Have you had a chest x-ray in the last 6 months? YES/NO _____

    If so please state: *Result*: _____
17. Have you ever undergone any surgery? YES/NO _____
18. Do you suffer from sleep apnoea? YES/NO _____
19. Do you intend to drive Taxis full or part-time? FULL/PART

Declaration and Authorisation (completed by applicant)
(if you have knowingly given false information in this examination you are liable to Prosecution)

Consent and Declaration This section MUST be completed and must NOT be altered in any way

Please sign the statement below:

I declare that I have checked the details I have given and that to the best of my knowledge they are correct.

If a medical condition is declared I authorise my Doctor(s) and Specialist(s) to release reports to the Council's Occupational Health Physician about my medical condition and that I will be liable for any additional cost incurred.

Signature _____ **Date** _____

Please remember to sign and date this form

MEDICAL IN CONFIDENCE

E. PHYSICAL EXAMINATION - TO BE COMPLETED BY THE COUNCIL'S MEDICAL ADVISER/THE APPLICANT'S GENERAL PRACTITIONER

VISION		Right	Left	Both
Distant	Unaided			
	With Glasses			
Near	Unaided			
	With Glasses			
Colour Vision:				

Height _____

Weight _____

Pulse Rate _____

Blood Pressure _____

Urine:

Albumin YES/NO

Sugar YES/NO

P.F.R. _____

X-Ray _____

ECG Report _____

F. INITIAL MEDICAL EXAMINATION - FOR COMPLETION BY THE COUNCIL'S MEDICAL ADVISER/THE APPLICANT'S GENERAL PRACTITIONER

N = Normal A = Abnormal

	N	A	Relevant History and Clinical Findings
1. General Physical Appearance			
2. Cardiovascular System			
3. Respiratory System			
4. Central Nervous System			
5. Musculo Skeletal System			
6. Genito Urinary System			
7. Gastro Intestinal System			
8. Hernial Orfices			
9. Lymphatic Glands			
10. Endocrine Disorders			
11. Metabolic Disorders			
12. Skin (including scars)			
13. Ears, Nose, Throat (including Hearing)			
14. Eyes (including Fundoscopy)			
15. Psyche			

Conclusions and Recommendations

A Fit for driving Taxis and Private Hire Vehicles
B Unfit
C Temporarily unfit. Re-examine in ..... month's time.

Remarks:

PERIODIC MEDICAL REVIEW

To be completed by Nurse and/or Doctor

Date			
Height	Weight		BP
Urine			
Vision	Right	Left	Both
Distant: Unaided			
With Glasses			
Near: Unaided			
With Glasses			
P.F.C.			

Date			
Height	Weight		BP
Urine			
Vision	Right	Left	Both
Distant: Unaided			
With Glasses			
Near: Unaided			
With glasses			
P.F.R.			

Date			
Height	Weight		BP
Urine			
Vision	Right	Left	Both
Distant: Unaided			
With glasses			
Near: Unaided			
With glasses			
P.F.R.			

Date			
Height	Weight		BP
Urine			
Vision	Right	Left	Both
Distant: Unaided			
With glasses			
Near: Unaided			
With glasses			
P.F.R.			

Any diseases, accidents, medical treatment since last examination Current Medication				
General Physical Appearance Cardiovascular System Respiratory System Central Nervous System/Psyche Skin Musculoskeletal VVS Hernial Orifices Hearing				
Recommendation (Category AF) Date of next examination Signature of Examiner				