Driver & Vehicle Licensing Agency

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

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

D4

Applicants: you must fill in all grey sections of this report. This includes the section below, your full name and date of birth at the end of each page and the declaration on page 8.

Important: This report is only valid for 4 months from date of examination.

Name

Date of birth D D M M Y Y

Address

Postcode

Contact number

Email address

Date first licensed to drive a bus or lorry D D M M Y Y

If you do not want to receive survey invitations by email from DVLA, please tick box ☐

Your doctor's details (only fill in **if different** from examining doctor's details)

GP's name

Practice address

Postcode

Contact number

Email address

Medical professionals must fill in all green sections on this report.

Important information for doctors carrying out examinations.

Before you fill in this report, you must check the applicant's identity and decide if you are able to fill in 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 fill in the Vision assessment.

Examining medical professional

Name

Has a company employed you or booked you to carry out this examination? Yes ☐ No ☐

If Yes, you **must** give the company's details below.

If 'No', you must give your practice address details below. (Refer to section C of INF4D.)

Company or practice address

Postcode

Company or practice contact number

Company or practice email address

GMC registration number

I can confirm that I have checked the applicant's documents to prove their identity.

Signature of examining doctor

Applicant's weight (kg)

Applicant's height (cm)

Number of alcohol units consumed each week

Units per week

Does the applicant smoke? Yes ☐ No ☐

Do you have access to the applicant's full medical record? Yes ☐ No ☐

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

7/21

Driver & Vehicle Licensing Agency

Medical examination report

Vision assessment

To be filled in by an optician, optometrist or doctor

D4

1. Please confirm (✓) the scale you are using to express the applicant's visual acuities.

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other.

(a) Please provide uncorrected visual acuities for each eye. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

R ☐ L ☐

(b) Are corrective lenses worn for driving? Yes ☐ No ☐
If No, go to Q3.

If Yes, please provide the visual acuities using the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

R ☐ L ☐

(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? Yes ☐ No ☐

(e) If correction is worn for driving, is it well tolerated? Yes ☐ No ☐
If No, please give full details in Q7.

3. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? Yes ☐ No ☐

If Yes, please give full details below.

☐

If formal visual field testing is considered necessary, DVLA will commission this at a later date.

4. Is there diplopia? Yes ☐ No ☐

(a) Is it controlled? Yes ☐ No ☐

Please indicate below and give full details in Q7.

Patch or glasses with frosted glass ☐ Glasses with/without prism ☐ Other (if other please provide details) ☐

5. Does the applicant report symptoms of any of the following that impairs their ability to drive? Yes ☐ No ☐

Please indicate below and give full details in Q7 below.

(a) Intolerance to glare (causing incapacity rather than discomfort) and/or ☐

(b) Impaired contrast sensitivity and/or ☐

(c) Impaired twilight vision ☐

6. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? Yes ☐ No ☐

If Yes, please give full details in Q7 below.

7. Details or additional information

☐

Name of examining doctor or optician undertaking vision assessment

☐

I confirm that this report was filled in by me at examination and the applicant's history has been taken into consideration.

Signature of examining doctor or optician

☐

Date of signature D D M M Y Y

Please provide your GOC or GMC number

☐

Doctor, optometrist or optician's stamp

☐

Applicant's full name ☐ **Date of birth** D D M M Y Y

Please do not detach this page

Driver & Vehicle Licensing Agency

Medical examination report

Medical assessment

Must be filled in by a doctor

D4

1 Neurological disorders

Please tick ✓ the appropriate boxes

Is there a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? Yes ☐ No ☐

If No, go to section 2, Diabetes mellitus

If Yes, please answer all questions below and enclose relevant hospital notes.

1. Has the applicant had any form of seizure? Yes ☐ No ☐

(a) Has the applicant had more than one seizure episode? Yes ☐ No ☐

(b) If Yes, please give date of first and last episode.

First episode D D M M Y Y

Last episode D D M M Y Y

(c) Is the applicant currently on anti-epileptic medication? Yes ☐ No ☐
If Yes, please fill in the medication section 8, page 6.

(d) If no longer treated, when did treatment end? D D M M Y Y

(e) Has the applicant had a brain scan? Yes ☐ No ☐
If Yes, please give details in section 9, page 7.

(f) Has the applicant had an EEG? Yes ☐ No ☐
If you have answered Yes to any of above, you must supply medical reports.

2. Has the applicant experienced dissociative/'non-epileptic' seizures? Yes ☐ No ☐

(a) If Yes, please give date of most recent episode. D D M M Y Y

(b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving? Yes ☐ No ☐

3. Stroke or TIA? Yes ☐ No ☐

If Yes, give date. D D M M Y Y

(a) Has there been a **full** recovery? Yes ☐ No ☐

(b) Has a carotid ultrasound been undertaken? Yes ☐ No ☐

(c) If Yes, was the carotid artery stenosis >50% in either carotid artery? Yes ☐ No ☐

(d) Is there a history of multiple strokes/TIAs? Yes ☐ No ☐

4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur? Yes ☐ No ☐

5. Subarachnoid haemorrhage (non-traumatic)? Yes ☐ No ☐

6. Significant head injury within the last 10 years? Yes ☐ No ☐

7. Any form of brain tumour? Yes ☐ No ☐

8. Other intracranial pathology? Yes ☐ No ☐

9. Chronic neurological disorder(s)? Yes ☐ No ☐

10. Parkinson's disease? Yes ☐ No ☐

11. Blackout, impaired consciousness or loss of awareness within the last 10 years? Yes ☐ No ☐

2 Diabetes mellitus

Does the applicant have diabetes mellitus? Yes ☐ No ☐

If No, go to section 3, Cardiac

If Yes, please answer all questions below.

1. Is the diabetes managed by:

(a) Insulin? Yes ☐ No ☐
If No, go to 1c
If Yes, please give date started on insulin. D D M M Y Y

(b) Are there at least 3 continuous months of blood glucose readings stored on a memory meter or meters? Yes ☐ No ☐
If No, please give details in section 9, page 7.

(c) Other injectable treatments? Yes ☐ No ☐

(d) A Sulphonylurea or a Glinide? Yes ☐ No ☐

(e) Oral hypoglycaemic agents and diet? Yes ☐ No ☐
If Yes to any of (a) to (e), please fill in the medication section 8, page 6.

(f) Diet only? Yes ☐ No ☐

2. (a) Does the applicant test blood glucose at least twice every day? Yes ☐ No ☐

(b) Does the applicant test at times relevant to driving (no more than 2 hours before the start of the first journey and every 2 hours while driving)? Yes ☐ No ☐

(c) Does the applicant keep fast-acting carbohydrate within easy reach when driving? Yes ☐ No ☐

(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? Yes ☐ No ☐

3. (a) Has the applicant ever had a hypoglyaemic episode? Yes ☐ No ☐

(b) If Yes, is there full awareness of hypoglycaemia? Yes ☐ No ☐

4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? Yes ☐ No ☐
If Yes, please give details and dates below.

5. Is there evidence of:

(a) Loss of visual field? Yes ☐ No ☐

(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? Yes ☐ No ☐

If Yes, please give details in section 9, page 7.

6. Has there been laser treatment or intra-vitreal treatment for retinopathy? Yes ☐ No ☐

If Yes, please give most recent date of treatment. D D M M Y Y

Applicant's full name

Date of birth D D M M Y Y

3 Cardiac

a Coronary artery disease

Is there a history or evidence of coronary artery disease? Yes ☐ No ☐

If No, go to section 3b, Cardiac arrhythmia

If Yes, please answer all questions below and enclose relevant hospital notes.

1. Has the applicant ever had an episode of angina? Yes ☐ No ☐

   If Yes, please give the date of the last known attack. D D M M Y Y

2. Acute coronary syndrome including myocardial infarction? Yes ☐ No ☐

   If Yes, please give date. D D M M Y Y

3. Coronary angioplasty (PCI)? Yes ☐ No ☐

   If Yes, please give date of most recent intervention. D D M M Y Y

4. Coronary artery bypass graft surgery? Yes ☐ No ☐

   If Yes, please give date. D D M M Y Y

5. If Yes to any of the above, are there any physical health problems or disabilities (e.g. mobility, arthritis or COPD) that would make the applicant unable to undertake 9 minutes of the standard Bruce Protocol ETT? Please give details below. Yes ☐ No ☐

b Cardiac arrhythmia

Is there a history or evidence of cardiac arrhythmia? Yes ☐ No ☐

If No, go to section 3c, Peripheral arterial disease

If Yes, please answer all questions below and enclose relevant 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? Yes ☐ No ☐

2. Has the arrhythmia been controlled satisfactorily for at least 3 months? Yes ☐ No ☐

3. Has an ICD (Implanted Cardiac Defibrillator) or biventricular pacemaker with defibrillator/ cardiac resynchronisation therapy defibrillator (CRT-D type) been implanted? Yes ☐ No ☐

4. Has a pacemaker or a biventricular pacemaker/ cardiac resynchronisation therapy pacemaker (CRT-P type) been implanted? Yes ☐ No ☐

   If Yes:

   (a) Please give date of implantation. D D M M Y Y

   (b) Is the applicant free of the symptoms that caused the device to be fitted? ☐ ☐

   (c) Does the applicant attend a pacemaker clinic regularly? ☐ ☐

c Peripheral arterial disease (excluding Buerger's disease) aortic aneurysm/dissection

Is there a history or evidence of peripheral arterial disease (excluding Buerger's disease), aortic aneurysm or dissection? Yes ☐ No ☐

If No, go to section 3d, Valvular/congenital heart disease

If Yes, please answer all questions below and enclose relevant hospital notes.

1. Peripheral arterial disease? (excluding Buerger's disease) Yes ☐ No ☐

2. Does the applicant have claudication? Yes ☐ No ☐

   If Yes, would the applicant be able to undertake 9 minutes of the standard Bruce Protocol ETT? ☐ ☐

3. Aortic aneurysm? Yes ☐ No ☐

   If Yes:

   (a) Site of aneurysm: Thoracic ☐ Abdominal ☐

   (b) Has it been repaired successfully? ☐ ☐

   (c) Please provide latest transverse aortic diameter measurement and date obtained using measurement and date boxes.

   ☐.☐ cm D D M M Y Y

4. Dissection of the aorta repaired successfully? Yes ☐ No ☐

   If Yes, please provide copies of all reports including those dealing with any surgical treatment.

5. Is there a history of Marfan's disease? 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? Yes ☐ No ☐

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 ☐

2. Is there a history of heart valve disease? Yes ☐ No ☐

3. Is there a history of aortic stenosis? Yes ☐ No ☐

   If Yes, please provide relevant reports (including echocardiogram).

4. Is there history of embolic stroke? Yes ☐ No ☐

5. Does the applicant currently have significant symptoms? Yes ☐ No ☐

6. Has there been any progression (either clinically or on scans etc) since the last licence application? Yes ☐ No ☐

Applicant's full name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **Date of birth** D D M M Y Y

e Cardiac other

Is there a history or evidence of heart failure? Yes No
If No, go to section 3f, Cardiac channelopathies
If Yes, please answer all questions and enclose relevant hospital notes.

1. Please provide the NYHA class, if known.
2. Established cardiomyopathy? Yes No
   If Yes, please give details in section 9, page 7.
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No
4. A heart or heart/lung transplant? Yes No
5. Untreated atrial myxoma? Yes No

f Cardiac channelopathies

Is there a history or evidence of the following conditions? Yes No
If No, go to section 3g, Blood pressure

1. Brugada syndrome? Yes No
2. Long QT syndrome? Yes No
   If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.

g Blood pressure

All questions must be answered.
If resting blood pressure is 180 mm/Hg systolic or more and/or 100mm/Hg diastolic or more, please take a further 2 readings at least 5 minutes apart and record the best of the 3 readings in the box provided.

1. Please record today's best resting blood pressure reading. /
2. Is the applicant on anti-hypertensive treatment? Yes No
   If Yes, please provide three previous readings with dates if available.
   / DDMMYY
   / DDMMYY
   / DDMMYY
3. Is there a history of malignant hypertension? Yes No
   If Yes, please give details in section 9, page 7 (including date of diagnosis and any treatment etc).

h Cardiac investigations

Have any cardiac investigations been undertaken or planned? Yes No
If No, go to section 4, Psychiatric illness
If Yes, please answer questions 1 to 7.

1. Has a resting ECG been undertaken? Yes No
   If Yes, does it show:
   (a) pathological Q waves?
   (b) left bundle branch block?
   (c) right bundle branch block?
   If Yes to (a), (b) or (c), please provide a copy of the relevant ECG report or comment in section 9, page 7.

Note: If Yes to questions 2 to 6, please give dates in the boxes provided, give details in section 9, page 7 and provide relevant reports.

2. Has an exercise ECG been undertaken (or planned)? DDMMYY Yes No
3. Has an echocardiogram been undertaken (or planned)? DDMMYY Yes No
   (a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?
4. Has a coronary angiogram been undertaken (or planned)? DDMMYY Yes No
5. Has a 24 hour ECG tape been undertaken (or planned)? DDMMYY Yes No
6. Has a loop recorder been implanted (or planned)? DDMMYY Yes No
7. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? DDMMYY Yes No

4 Psychiatric illness

Is there a history or evidence of psychiatric illness within the last 3 years? Yes No
If No, go to section 5, Substance misuse
If Yes, please answer all questions below.

1. Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition. Yes No
2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No
3. (a) Dementia or cognitive impairment? Yes No
   (b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses?

5 Substance misuse

Is there a history of drug/alcohol misuse or dependence? Yes No
If No, go to section 6, Sleep disorders
If Yes, please answer all questions below.

1. Is there a history of alcohol dependence in the past 6 years? Yes No
   (a) Is it controlled?
   (b) Has the applicant undergone an alcohol detoxification programme?
   If Yes, give date started: DDMMYY
2. Persistent alcohol misuse in the past 3 years? Yes No
   (a) Is it controlled?
3. Use of illegal drugs or other substances, or misuse of prescription medication in the last 6 years? Yes No
   (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 DDMMYY

Applicant's full name **Date of birth** DDMMYY

6 Sleep disorders

1. Is there a history or evidence of Obstructive Sleep Apnoea Syndrome or any other medical condition causing excessive sleepiness? Yes ☐ No ☐

If No, go to section 7, Other medical conditions.
If Yes, please give diagnosis and answer all questions below.

☐

a) If Obstructive Sleep Apnoea Syndrome, please indicate the severity:

Mild (AHI <15) ☐
Moderate (AHI 15 - 29) ☐
Severe (AHI >29) ☐
Not known ☐

If another measurement other than AHI is used, it 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.

b) Please answer questions (i) to (vi) for **all** sleep conditions.

(i) Date of diagnosis: D D M M Y Y

(ii) Is it controlled successfully? Yes ☐ No ☐

(iii) If Yes, please state treatment.

☐

(iv) Is applicant compliant with treatment? Yes ☐ No ☐

(v) Please state period of control:

☐ years ☐ months

(vi) Date of last review. D D M M Y Y

7 Other medical conditions

1. Is there a history or evidence of narcolepsy? Yes ☐ No ☐

2. Is there currently any functional impairment that is likely to affect control of the vehicle? Yes ☐ No ☐

3. Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? Yes ☐ No ☐

4. Is there any illness that may cause significant fatigue or cachexia that affects safe driving? Yes ☐ No ☐

5. Is the applicant profoundly deaf? Yes ☐ No ☐

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? Yes ☐ No ☐

6. Does the applicant have a history of liver disease of any origin? Yes ☐ No ☐

If Yes, is this the result of alcohol misuse? Yes ☐ No ☐

If Yes, please give details in section 9, page 7.

7. Is there a history of renal failure? Yes ☐ No ☐

If Yes, please give details in section 9, page 7.

8. Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? Yes ☐ No ☐

9. Does any medication currently taken cause the applicant side effects that could affect safe driving? Yes ☐ No ☐

If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.

10. Does the applicant have any other medical condition that could affect safe driving? Yes ☐ No ☐

If Yes, please provide details in section 9, page 7.

8 Medication

Please provide details of all current medication including eye drops (continue on a separate sheet if necessary).

Medication	Dosage
Reason for taking:	
Approximate date started (if known):	D D M M Y Y

Medication	Dosage
Reason for taking:	
Approximate date started (if known):	D D M M Y Y

Medication	Dosage
Reason for taking:	
Approximate date started (if known):	D D M M Y Y

Medication	Dosage
Reason for taking:	
Approximate date started (if known):	D D M M Y Y

Medication	Dosage
Reason for taking:	
Approximate date started (if known):	D D M M Y Y

Applicant's full name ☐ **Date of birth** D D M M Y Y

9 Further details

Please send us copies of relevant hospital notes. Do not send any notes not related to fitness to drive. Use the space below to provide any additional information.

10 Consultants' details

Please provide details of type of specialists or consultants, including address.

Consultant in
Reason for attendance
Name
Address

Date of last appointment: D D M M Y Y

Consultant in
Reason for attendance
Name
Address

Date of last appointment: D D M M Y Y

If more consultants seen give details on a separate sheet.

11 Examining doctor's signature and stamp

To be filled in by the doctor carrying out the examination.

Please make sure all sections of the form have been filled in. The form will be returned to you if you do not do this.

I confirm that this report was filled in 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 practise in the UK or I am a doctor who is medically registered within the EU, if the report was filled in outside the UK.

Signature of examining doctor

Date of signature D D M M Y Y

Doctor's stamp

Applicant's full name **Date of birth** D D M M Y Y

The applicant must fill in 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:

	Yes	No
inform my doctors about the outcome of my case	☐	☐
release reports to my doctor(s)	☐	☐

Contact me about my application by:

	Yes	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

	Yes
• Have you signed and dated the declaration?	☐
• Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?	☐

Important

This report is valid for 4 months from the date the doctor, optician or optometrist signs it.

Please return it together with your application form.