



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
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Address

Postcode

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Contact number

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Email address

Date first licensed to drive a bus or lorry

D	D	M	M	Y	Y
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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

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Contact number

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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

C	O	M	P	L	I	A	N	C	E											
M	E	D	I	C	A	L	S	E	R	V	I	C	E	S						
P	E	T	E	R	S	C	O	U	R	T										
C	I	T	Y		R	O	A	D												
P	E	T	E	R	B	O	R	O	U	G	H									

Postcode

P	E	1		1	S	A
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Company or practice contact number

0	2	0	3	9	8	5	5	8	0	0
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Company or practice email address

a	d	m	i	n	@	c	o	m	p	l	i	a	n	c
e	m	e	d	i	c	a	l	s	.	u	k			

GMC registration number

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

Signature of examining doctor

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Applicant's weight (kg)

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Applicant's height (cm)

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Number of alcohol units consumed each week

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 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



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 Yes No

(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

Please provide your GOC or GMC number

Doctor, optometrist or optician's stamp

Applicant's full name

Date of birth

Please do not detach this page



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? No
 - (b) If Yes, please give date of first and last episode.

First episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Last episode	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
 - (c) Is the applicant currently on anti-epileptic medication? No
If Yes, please fill in the medication section 8, page 6.
 - (d) If no longer treated, when did treatment end?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 - (e) Has the applicant had a brain scan? No
If Yes, please give details in section 9, page 7.
 - (f) Has the applicant had an EEG? 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.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 - (b) If Yes, have any of these episode(s) occurred or are they considered likely to occur whilst driving? No
- 3. Stroke or TIA? Yes No
If Yes, give date.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 - (a) Has there been a **full** recovery? No
 - (b) Has a carotid ultrasound been undertaken? No
 - (c) If Yes, was the carotid artery stenosis >50% in either carotid artery? No
 - (d) Is there a history of multiple strokes/TIAs? No
- 4. Sudden and disabling dizziness or vertigo within the last year with a liability to recur? No
- 5. Subarachnoid haemorrhage (non-traumatic)? No
- 6. Significant head injury within the last 10 years? No
- 7. Any form of brain tumour? No
- 8. Other intracranial pathology? No
- 9. Chronic neurological disorder(s)? No
- 10. Parkinson's disease? No
- 11. Blackout, impaired consciousness or loss of awareness within the last 10 years? 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: Yes No
 - (a) Insulin? No
If No, go to 1c
 - If Yes, please give date started on insulin.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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 - (b) Are there at least 3 continuous months of blood glucose readings stored on a memory meter or meters? No
If No, please give details in section 9, page 7.
 - (c) Other injectable treatments? No
 - (d) A Sulphonylurea or a Glinide? No
 - (e) Oral hypoglycaemic agents and diet? No
If Yes to any of (a) to (e), please fill in the medication section 8, page 6.
 - (f) Diet only? 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)? No
(c) Does the applicant keep fast-acting carbohydrate within easy reach when driving? No
(d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? No
- 3. (a) Has the applicant ever had a hypoglycaemic episode? Yes No
(b) If Yes, is there full awareness of hypoglycaemia? 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: Yes No
 - (a) Loss of visual field? No
 - (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? No
 If Yes, please give details in section 9, page 7.
- 6. Has there been laser treatment or intra-vitreous treatment for retinopathy? Yes No
If Yes, please give most recent date of treatment.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Applicant's full name	<input style="width: 100%;" type="text"/>	Date of birth	<input style="width: 100%;" type="text"/>
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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.

2. Acute coronary syndrome including myocardial infarction? Yes No

If Yes, please give date.

3. Coronary angioplasty (PCI)? Yes No

If Yes, please give date of most recent intervention.

4. Coronary artery bypass graft surgery? Yes No

If Yes, please give date.

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.

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

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

Applicant's full name

Date of birth

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

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

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.
- Please provide the NYHA class, if known.
 - Established cardiomyopathy? Yes No
 If Yes, please give details in section 9, page 7.
 - Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted? Yes No
 - A heart or heart/lung transplant? Yes No
 - 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
- Brugada syndrome? Yes No
 - 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.
- Please record today's best resting blood pressure reading. /
 - Is the applicant on anti-hypertensive treatment? Yes No
 If Yes, please provide three previous readings with dates if available.

	/	
	/	
	/	

D	D	M	M	Y	Y
D	D	M	M	Y	Y
D	D	M	M	Y	Y
 - 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.
- 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.

- Has an exercise ECG been undertaken (or planned)? Yes No
- Has an echocardiogram been undertaken (or planned)? Yes No

 (a) If undertaken, is or was the left ejection fraction greater than or equal to 40%?
- Has a coronary angiogram been undertaken (or planned)? Yes No
- Has a 24 hour ECG tape been undertaken (or planned)? Yes No
- Has a loop recorder been implanted (or planned)? Yes No
- Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? 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.
- Significant psychiatric disorder within the past 6 months? If Yes, please confirm condition. Yes No
 - Psychosis or hypomania/mania within the past 12 months, including psychotic depression? Yes No
 - (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.
- 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:
 - Persistent alcohol misuse in the past 3 years? Yes No

 (a) Is it controlled?
 - 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

Applicant's full name

Date of birth

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: Yes No

(ii) Is it controlled successfully?

(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.

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?

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): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Medication	Dosage
Reason for taking:	
Approximate date started (if known): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

Applicant's full name

Date of birth

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	<input type="checkbox"/>	<input type="checkbox"/>
release reports to my doctor(s)	<input type="checkbox"/>	<input type="checkbox"/>

Contact me about my application by:

	Yes	No
email	<input type="checkbox"/>	<input type="checkbox"/>
SMS (text message)	<input type="checkbox"/>	<input type="checkbox"/>

(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?	<input type="checkbox"/>
• Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have been enclosed?	<input type="checkbox"/>

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.