

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.

this report.



Medical professionals must fill in all green sections on

Important information for doctors carrying

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	out examinations.
4 months from date of examination.	Before you fill in this report, you must check the applicant's
	identity and decide if you are able to fill in the Vision
Name	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.
	optician or optometrist to fill in the vision assessment.
Data of birth	Examining medical professional
Date of birth	Name
Address	
	Has a company employed you or booked
	you to carry out this examination?
	If Yes, you must give the company's details below.
	If 'No', you must give your practice address details below.
Postcode	(Refer to section C of INF4D.)
Contact number	Company or practice address
Email address	
Date first licensed to drive a bus or lorry	
DDMMVV	
	Postcode
If you do not want to receive survey invitations by email from	Company or practice contact number
DVLA, please tick box	
Your doctor's details (only fill in if different from examining doctor's details)	
,	Company or practice email address
GP's name	
	GMC registration number
Practice address	Civic registration number
Tractice address	
	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)
Postcode	
Postcode	
Contact number	Number of alcohol units consumed each week
	Units 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



Medical examination report

Vision assessment



I 1/4L

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 report symptoms of any of the following that impairs their ability to drive? Please indicate below and give full details.
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?	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? If Yes, please give full details in Q7 below.
	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 (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, is it well tolerated?	7. Details or additional information Name of examining doctor or optician undertaking vision assessment
3.	If No, please give full details in Q7. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? If Yes, please give full details below. If formal visual field testing is considered necessary, DVLA will commission this at a later date.	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
4.	Is there diplopia? (a) Is it controlled? Please indicate below and give full details in Q7. Patch or Glasses Other glasses with frosted glass prism (if other please provide details)	Doctor, optometrist or optician's stamp
Ap	plicant's full name Please do not o	Date of birth DDMMYY detach this page



Medical examination report

Medical assessment

Must be filled in by a doctor

D4

1 Neurological disorders	2 Diabetes mellitus
Please tick ✓ the appropriate boxes Is there a history or evidence of any neurological disorder (see conditions in questions 1 to 11 below)? If No, go to section 2, Diabetes mellitus If Yes, please answer all questions below and enclose relevant hospital notes.	Yes No Does the applicant have diabetes mellitus? If No, go to section 3, Cardiac If Yes, please answer all questions below. 1. Is the diabetes managed by: (a) Insulin? Yes No Yes No
Yes No 1. Has the applicant had any form of seizure? (a) Has the applicant had more than one seizure episode? (b) If Yes, please give date of first and last episode. First episode Last episode	If No, go to 1c If Yes, please give date started on insulin. (b) Are there at least 3 continuous months of blood glucose readings stored on a memory meter or meters? If No, please give details in section 9, page 7. (c) Other injectable treatments?
(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?	(d) A Sulphonylurea or a Glinide? (e) Oral hypoglycaemic agents and diet? If Yes to any of (a) to (e), please fill in the medication section 8, page 6. (f) Diet only?
If Yes, please give details in section 9, page 7. (f) Has the applicant had an EEG? If you have answered Yes to any of above, you must supply medical reports.	 (a) Does the applicant test blood glucose at least twice every day? (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. Has the applicant experienced dissociative/'non-epileptic' seizures? (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?	2 hours while driving)? (c) Does the applicant keep fast-acting carbohydrate within easy reach when driving? (d) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?
3. Stroke or TIA? If Yes, give date. (a) Has there been a full recovery?	(a) Has the applicant ever had a hypoglyaemic episode?(b) If Yes, is there full awareness of hypoglycaemia?
(b) Has a carotid ultrasound been undertaken? (c) If Yes, was the carotid artery stenosis >50% in either carotid artery? (d) Is there a history of multiple strokes/TIAs?	4. Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? If Yes, please give details and dates below.
within the last year with a liability to recur? 5. Subarachnoid haemorrhage (non-traumatic)?	
6. Significant head injury within the last 10 years?	5. Is there evidence of: (a) Loss of visual field? Yes No
7. Any form of brain tumour?	(b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving?
8. Other intracranial pathology?	If Yes, please give details in section 9, page 7.
9. Chronic neurological disorder(s)?	6. Has there been laser treatment or Yes No
10. Parkinson's disease?	intra-vitreal treatment for retinopathy? If Yes, please give
11. Blackout, impaired consciousness or loss of awareness within the last 10 years?	most recent date of treatment.
Applicant's full name	Date of birth DDMMYY

3 Cardiac		С	Peripheral arterial disease (excluding Buerger's disease)	·
a Coronary artery diseas	е		aortic aneurysm/dissection	
Is there a history or evidence of coronary artery disease? If No, go to section 3b, Cardiac a If Yes, please answer all questions and enclose relevant hospital notes	below	art ao	there a history or evidence of peripheral terial disease (excluding Buerger's disease), rtic aneurysm or dissection? No, go to section 3d, Valvular/congenital heat yes, please answer all questions below and close relevant hospital notes.	Yes No rt disease
1. Has the applicant ever had an e of angina?	episode Yes	No	Peripheral arterial disease?	Yes No
If Yes, please give the date of the last known attack.	DMMYY		(excluding Buerger's disease)	Yes No
2. Acute coronary syndrome include myocardial infarction?	ding Yes	No 2.	Does the applicant have claudication? If Yes, would the applicant be able to undertake 9	
If Yes, please give date. 3. Coronary angioplasty (PCI)?	Yes	No	minutes of the standard Bruce Protocol ETT?	
If Yes, please give date of most recent intervention.	MMYY	3.	Aortic aneurysm? If Yes:	Yes No
4. Coronary artery bypass graft su	urgery? Yes	No	(a) Site of aneurysm: Thoracic Abdominal	
If Yes, please give date.	MMYY		(b) Has it been repaired successfully?(c) Please provide latest transverse aortic diameter measurement and date obtained	
5. If Yes to any of the above, are the physical health problems or disa (e.g. mobility, arthritis or COPD) the applicant unable to undertake standard Bruce Protocol ETT? P	abilities that would make se 9 minutes of the	No Dow.	using measurement and date boxes.	
			Dissection of the aorta repaired successfully? If Yes, please provide copies of all reports including those dealing with any surgical treatr	Yes No
			morading those dealing with any surgicul treati	iloit.
		5	Is there a history of Marfan's disease?	Yes No
b Cardiac arrhythmia		5.	Is there a history of Marfan's disease? If Yes, please provide relevant hospital notes.	Yes No
Is there a history or evidence of cardiac arrhythmia?	Yes	5.	If Yes, please provide relevant hospital notes.	Yes No
Is there a history or evidence of	l arterial disease	No d	If Yes, please provide relevant hospital notes.	Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral If Yes, please answer all questions relevant hospital notes. 1. Has there been a significant dis of cardiac rhythm? (e.g. sinoatr	l arterial disease below and enclose sturbance ial disease,	No d ls va lf lf 'rel	If Yes, please provide relevant hospital notes. Valvular/congenital heart disease there a history or evidence of lyular or congenital heart disease?	
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral If Yes, please answer all questions relevant hospital notes. 1. Has there been a significant dis	l arterial disease below and enclose sturbance ial disease, duction defect, w or broad	No d ls va If I If Y rel	Valvular/congenital heart disease there a history or evidence of lvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide	
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral If Yes, please answer all questions relevant hospital notes. 1. Has there been a significant dis of cardiac rhythm? (e.g. sinoatr significant atrio-ventricular condatrial flutter or fibrillation, narrow complex tachycardia) in the last	l arterial disease below and enclose sturbance ial disease, duction defect, w or broad t 5 years? Olled Yes ths?	No d ls va If I If Y rel	Valvular/congenital heart disease there a history or evidence of lvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide evant hospital notes.	Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral If Yes, please answer all questions relevant hospital notes. 1. Has there been a significant dis of cardiac rhythm? (e.g. sinoatr significant atrio-ventricular condatrial flutter or fibrillation, narrow complex tachycardia) in the last	l arterial disease below and enclose sturbance ial disease, duction defect, w or broad t 5 years? Defibrillator) defibrillator/	No d ls va lf lf 'rel No 1. No 2.	Valvular/congenital heart disease there a history or evidence of lvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide evant hospital notes. 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 If Yes, please answer all questions relevant hospital notes. 1. Has there been a significant dist of cardiac rhythm? (e.g. sinoatr significant atrio-ventricular condatrial flutter or fibrillation, narrow complex tachycardia) in the last. 2. Has the arrhythmia been control satisfactorily for at least 3 monts. 3. Has an ICD (Implanted Cardiac or biventricular pacemaker with cardiac resynchronisation thera (CRT-D type) been implanted? 4. Has a pacemaker or a biventricular cardiac resynchronisation therapy (CRT-P type) been implanted?	l arterial disease below and enclose sturbance ial disease, duction defect, w or broad t 5 years? Defibrillator) defibrillator/upy defibrillator/upy defibrillator	No d ls va lf l lf rel No 1. No 2. No 3.	Valvular/congenital heart disease there a history or evidence of lvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide evant hospital notes. Is there a history of congenital heart disease? Is there a history of heart valve disease? Is there a history of aortic stenosis? If Yes, please provide relevant reports	Yes No Yes No Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral If Yes, please answer all questions relevant hospital notes. 1. Has there been a significant dis of cardiac rhythm? (e.g. sinoatr significant atrio-ventricular condatrial flutter or fibrillation, narrow complex tachycardia) in the last. 2. Has the arrhythmia been controsatisfactorily for at least 3 mont. 3. Has an ICD (Implanted Cardiac or biventricular pacemaker with cardiac resynchronisation thera (CRT-D type) been implanted? 4. Has a pacemaker or a biventricular cardiac resynchronisation therapy	l arterial disease below and enclose sturbance ial disease, duction defect, w or broad t 5 years? Defibrillator) defibrillator/upy defibrillator/upy defibrillator	No d ls va lf lf \(\text{If No} \) no 1. No \(\text{No} \) 2. \(\text{No} \) No \(\text{No} \) \(No	Valvular/congenital heart disease there a history or evidence of lvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide evant hospital notes. Is there a history of congenital heart disease? 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 Yes No
Is there a history or evidence of cardiac arrhythmia? If No, go to section 3c, Peripheral If Yes, please answer all questions relevant hospital notes. 1. Has there been a significant dist of cardiac rhythm? (e.g. sinoatr significant atrio-ventricular condatrial flutter or fibrillation, narrow complex tachycardia) in the last. 2. Has the arrhythmia been controsatisfactorily for at least 3 monts. 3. Has an ICD (Implanted Cardiac or biventricular pacemaker with cardiac resynchronisation thera (CRT-D type) been implanted? 4. Has a pacemaker or a biventricular cardiac resynchronisation therapy (CRT-P type) been implanted? If Yes: (a) Please give date	l arterial disease below and enclose sturbance ial disease, duction defect, w or broad t 5 years? Defibrillator) defibrillator/	No d ls va lf lf lf rel No 1. No 2. No No 4. 5.	Valvular/congenital heart disease there a history or evidence of lvular or congenital heart disease? No, go to section 3e, Cardiac other Yes, answer all questions below and provide evant hospital notes. Is there a history of congenital heart disease? Is there a history of heart valve disease? Is there a history of aortic stenosis? If Yes, please provide relevant reports (including echocardiogram). Is there history of embolic stroke? Does the applicant currently have	Yes No Yes No Yes No Yes No Yes No

e Cardiac other		provided, give details in section 9, page 7 and provide relevant report
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	Yes No	2. Has an exercise ECG been undertaken Yes No (or planned)?
relevant hospital notes. 1. Please provide the NYHA class, if known.		3. Has an echocardiogram been undertaken Yes No (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%?
3. Has a left ventricular assist device (LVAD) or other cardiac assist device been implanted?	Yes No	4. 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 (or planned)?
5. Untreated atrial myxoma?	Yes No	6. Has a loop recorder been implanted Yes No (or planned)?
f Cardiac channelopathies		7 Haraman and a reference at the second state of the second state
Is there a history or evidence of the following conditions? If No, go to section 3g, Blood pressure	Yes No	7. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)?
1. Brugada syndrome?	Yes No	4 Psychiatric illness
2. Long QT syndrome? If Yes to either, please give details in section 9, page 7 and enclose relevant hospital notes.	Yes No	Is there a history or evidence of psychiatric illness within the last 3 years? If No, go to section 5, Substance misuse If Yes, please answer all questions below.
g Blood pressure		Significant psychiatric disorder within the Yes No past 6 months? If Yes, please confirm condition.
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.	further	2. Psychosis or hypomania/mania within the past 12 months, including psychotic depression?
Please record today's best resting blood pressure reading. /	Vaa Na	3. (a) Dementia or cognitive impairment? (b) Are there concerns which have resulted
2. Is the applicant on anti-hypertensive treatment? If Yes, please provide three previous readings with dates if available.	Yes No	in ongoing investigations for such possible diagnoses?
/ DDMM	YY	5 Substance misuse
	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	Is there a history of alcohol dependence Yes No in the past 6 years?
page 7 (including date of diagnosis and any treatr	ment etc).	(a) Is it controlled? (b) Has the applicant undergone an alcohol detoxification programme?
Have any cardiac investigations been undertaken or planned?	Yes No	If Yes, give date started:
If No, go to section 4, Psychiatric illness If Yes, please answer questions 1 to 7.		2. Persistent alcohol misuse in the past 3 years? (a) Is it controlled? Yes No
1. Has a resting ECG been undertaken? If Yes, does it show:(a) pathological Q waves?(b) left bundle branch block?	Yes No	3. Use of illegal drugs or other substances, or misuse Yes No of prescription medication in the last 6 years? (a) If Yes, the type of substance misused?
(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.	(b) Is it controlled? (c) Has the applicant undertaken an opiate treatment programme? If Yes, give date started
Applicant's full name		Pate of birth

6	Sleep disorders	6. 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	of liver disease of any origin? If Yes, is this the result of alcohol misuse?
	condition causing excessive sleepiness? If No, go to section 7, Other medical conditions.	If Yes, please give details in section 9, page 7.
	If Yes, please give diagnosis and answer all questions	7. Is there a history of renal failure? Yes No
	below.	If Yes, please give details in section 9, page 7.
	a) If Obstructive Sleep Apnoea Syndrome, please	8. Does the applicant have severe symptomatic Yes No respiratory disease causing chronic hypoxia?
	indicate the severity:	
	Mild (AHI <15) Moderate (AHI 15 - 29)	9. Does any medication currently taken cause the applicant side effects that could affect
	Severe (AHI >29)	safe driving?
	Not known	If Yes, please fill in section 8, Medication and give symptoms in section 9, page 7.
	If another measurement other than AHI is used, it must be one that is recognised in clinical practice	10. Does the applicant have any other medical Yes No
	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.	condition that could affect safe driving? If Yes, please provide details in section 9, page 7.
	b) Please answer questions (i) to (vi) for all sleep conditions.	8 Medication
	(i) Date of diagnosis:	
	(ii) Is it controlled successfully?	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
	(iv) Is applicant compliant with treatment?	Reason for taking:
	(v) Please state period of control:	Approximate date started (if known):
	years months	Medication Dosage
	(vi) Date of last review.	Reason for taking:
_		Approximate date started (if known):
7	Other medical conditions	, pp o minute date contest (i. in e iii.)
1.	Is there a history or evidence of narcolepsy?	Medication Dosage
2.	Is there currently any functional impairment Yes No	Reason for taking:
	that is likely to affect control of the vehicle?	Approximate date started (if known):
3.	Is there a history of bronchogenic carcinoma Yes No or other malignant tumour with a significant	
	liability to metastasise cerebrally?	Medication Dosage
1	Is there any illness that may cause significant Yes No	December for talkings
٦.	fatigue or cachexia that affects safe driving?	Reason for taking:
	Yes No	Approximate date started (if known):
5.	Is the applicant profoundly deaf?	Medication Dosage
	If Yes, is the applicant able to communicate in the event of an emergency by speech Yes No	Modication
	or by using a device, e.g. a textphone?	Reason for taking:
		Approximate date started (if known):
Α	plicant's full name	Date of birth
AD	olicant's full name	The state of birth and

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 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
	Doctor's stamp
Applicant's full name	Date of birth DDMMYY

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.

Signature		
Date		
I authorise the Secretary of Stat		
inform my doctors about	Yes	No
the outcome of my case	Ш	Ш
release reports to my doctor(s)		
Contact me about my application	•	
	Yes	No
email	H	H
SMS (text message) (Please note: DVLA will continue		ш
to contact you by post if you do wish to be contacted by email or	not)
Checklist		Yes
 Have you signed and dated the declaration? 		
the declaration?Have you checked that the optician or doctor has filled		Yes
the declaration? • Have you checked that the		Yes
 the declaration? Have you checked that the optician or doctor has filled in all parts of the report and all relevant hospital notes have 		Yes
 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 the date the doctor, optician or 		Yes
 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	Yes
 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 the date the doctor, optician or optometrist signs it. 	from	Yes
 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 the date the doctor, optician or optometrist signs it. Please return it together with your particular or optometrist. 	from	Yes