This document is valid for use between 10 February 2020 and 31 December 2020, subject to legal amendments.

City of Wolverhampton Council Licensing Services

Hackney Carriages and Private Hire Drivers
Medical Certificate

Full Name of Applicant (BLOCK CAPITALS)_____

Address_____**Postcode**_____

I hereby authorise my doctor(s) and specialists to release reports/medical information to the Medical Practitioner, should they require further information about condition(s) relevant to my fitness to drive to group 2 standard.

Signature of applicant _____

(To be signed in the presence of the medical practitioner signing this certificate)

You are 'Assessing Fitness to Drive' at DVLA Group 2 Standard, a guidance for medical professionals is available online at https://www.gov.uk/guidance/assessing-fitness-to-drive-a-guide-for-medical-professionals

I certify that I have this day examined the applicant, who has signed this form in my presence and has their two forms of identification as indicated below who is in my opinion,

Medically fit ❑ **Medically unfit** ❑ to drive a hackney carriage or private hire vehicle.

Date of Birth of applicant_____ Age of applicant_____

Medical certification frequency requirement

- A new certificate must be produced every 5 years after the applicants 45th birthday.
- Once the age of 65 is reached, a medical certificate must be produced every year.

Earlier medical certification frequency requirement

The above medical certification frequency is **not** sufficient: ❑ (tick box, if applicable)

I recommend that the applicant is examined no later than: (insert date) _____

The applicant has provided one from each type of the following forms of identification, please indicate:

Type 1 Passport ❑ Driving Licence ❑

Type 2 Utility Bill (gas, electric, telephone, water) ❑ Bank Statement ❑

Birth Certificate ❑ Marriage/ Civil Partnership Certificate ❑

Signature of GMC registered Medical Practitioner_____ **Date**_____

GMC Reference Number |____|____|____|____|____|____|____|

Name (BLOCK CAPITALS)_____

Please add address and phone number
or Medical Practice Address Stamp
No disclaimers are acceptable.