This document is valid for use between 1 January 2021 and 31 December 2021, subject to legal amendments.

City of Wolverhampton Council Licensing Services
Hackney Carriage 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

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

Please Tick: **Type 1;** Passport ❑ Driving Licence ❑

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

Birth Certificate ❑ Marriage/ Civil Partnership Certificate ❑

Date of Birth of applicant | D | D | M | M | Y | Y | Y | Y | Age of applicant | | |

Medical certification frequency requirement

- Once the age of **45** is reached, a medical certificate must be produced every 5 years.
- 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) | D | D | M | M | Y | Y | Y | Y |

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

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

Signature of GMC registered Medical Practitioner ______________________________

Date | D | D | M | M | Y | Y | Y | Y |

GMC Reference Number | | | | | | | |

Name (BLOCK CAPITALS)____

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