



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. 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

--	--	--	--	--	--	--	--

Contact number (optional)

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Email address (optional)

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

--	--	--	--	--	--	--	--	--	--	--	--	--

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

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Company or practice contact number

--	--	--	--	--	--	--	--	--	--	--	--	--

Company or practice email address

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)

Applicant's height (cm)

--	--	--	--	--	--	--	--	--	--	--	--	--

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Do you have access to the applicant's full medical record?

Yes ☐ No ☐

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



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 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 Q8.

3. Is there a known visual field defect? Yes ☐ No ☐

4. Are there any medical conditions which might result in a visual field defect? Yes ☐ No ☐

- (a) If yes, has a visual field defect been excluded? Yes ☐ No ☐

- (b) Please provide the condition:

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

5. Is there diplopia? Yes ☐ No ☐

- (a) Is it controlled? Yes ☐ No ☐

Please indicate below and give full details in Q8.

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

6. 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 Q8 below.

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

(b) Impaired contrast sensitivity and/or ☐

(c) Impaired twilight vision ☐

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

If yes, please give full details in Q8 below.

8. Details or additional information

Name of examining doctor, optician or optometrist 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, optician or optometrist

Date of signature

D	D	M	M	Y	Y
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Please provide your GOC or GMC number

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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



1 Neurological disorders

Please tick ✓ the appropriate boxes

Does the applicant have 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.

1. Has the applicant had any form of seizure?

Yes No
☐ ☐

(a) Has the applicant had more than one seizure episode?

☐ ☐

(b) Please give date of first and last episode.

First episode

Last episode

(c) Is the applicant currently on anti-seizure medication?

☐ ☐

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

(e) Has the applicant had a brain scan?

☐ ☐

If yes, please give details in section 9, page 6.

2. Has the applicant experienced any dissociative/functional seizures?

Yes No
☐ ☐

(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?

☐ ☐

3. Stroke or TIA?

Yes No
☐ ☐

If yes, give date.

(a) Has there been a full recovery?

☐ ☐

(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. Sudden and disabling dizziness or vertigo within the last year with a liability to recur?

☐ ☐

5. Subarachnoid haemorrhage (non-traumatic)?

☐ ☐

6. Significant head injury within the last 10 years?

☐ ☐

7. Any form of brain tumour?

☐ ☐

8. Other intracranial pathology?

☐ ☐

9. Chronic neurological disorder(s)?

☐ ☐

10. Parkinson's disease?

☐ ☐

11. Blackout, impaired consciousness or loss of awareness within the last 5 years?

☐ ☐

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 treated by:

Yes No
☐ ☐

(a) Insulin?

☐ ☐

If no, go to 1c

If yes, please give date started on insulin.

(b) Are there at least 4 continuous weeks of glucose readings stored on a memory meter or meters?

☐ ☐

If no, please give details in section 9, page 6.

(c) Other injectable treatments?

☐ ☐

(d) A Sulphonylurea or a Glinide?

☐ ☐

(e) Oral hypoglycaemic agents and diet?

☐ ☐

(f) Diet only?

☐ ☐

2. (a) Does the applicant monitor their glucose level using continuous glucose monitoring (CGM)?

Yes No
☐ ☐

(b) If yes, is the continuous glucose monitoring (CGM) device approved for non-adjunctive use?

☐ ☐

(c) Does the applicant carry a finger prick monitoring device?

☐ ☐

(d) Does the applicant test glucose at least twice every day?

☐ ☐

(e) Does the applicant test glucose at times relevant to driving? (Within 2 hours of starting their first journey of the day and continuing to check at least every 2 hours during their journey. There must be no more than 2 hours between glucose checks at any time during their journey).

☐ ☐

(f) Does the applicant keep fast-acting carbohydrate within easy reach whilst driving?

☐ ☐

(g) Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving?

☐ ☐

3. (a) Has the applicant ever had a hypoglycaemic episode?

Yes No
☐ ☐

(b) Is there full awareness of hypoglycaemia?

☐ ☐

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. Has there been laser treatment or intra-vitreous treatment for retinopathy?

Yes No
☐ ☐

If yes, please give most recent date of treatment.

Applicant's full name

Date of birth

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 below.

1. Please provide the NYHA class, if known.

2. Established cardiomyopathy? Yes No

If yes, please give details in section 9, page 6.

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. Evidence or history of pulmonary arterial hypertension? 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 6.

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

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 5.

1. Is there a history of the following: Yes No
(a) left bundle branch block (LBBB)?
(b) right bundle branch block (RBBB)?
(c) paced rhythm?

If yes to (a), (b) or (c), please give details in section 9, page 6.

Note: If yes to questions 2 to 5, please give dates in the boxes provided, give details in section 9, page 6.

2. Has an exercise ECG been undertaken (or planned)? Yes No

DDMMYY

3. Has an echocardiogram been undertaken (or planned)? Yes No

DDMMYY

(a) If undertaken, is or was the left ejection fraction greater than or equal to 40%? Yes No

4. Has a coronary angiogram been undertaken (or planned)? Yes No

DDMMYY

5. Has a myocardial perfusion scan, stress echo study or cardiac MRI been undertaken (or planned)? Yes No

DDMMYY

4 Psychiatric illness

Is there any significant mental illness or cognitive impairment likely to affect safe driving? 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? Yes No

3. Severe depression within the past 6 months? Yes No

4. (a) Dementia or cognitive impairment? Yes No
(b) Are there concerns which have resulted in ongoing investigations for such possible diagnoses? Yes No

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 an alcohol use disorder (sufficient to cause significant physical, mental or social consequences) in the past 10 years? Yes No

2. If there is a history of an alcohol use disorder, has this been associated with any of the following features which indicate a physiological dependence on alcohol: Yes No

(a) Required medical assisted withdrawal? Yes No

Date treatment ended: DDMMYY

(b) Alcohol withdrawal seizure? Yes No

Date of last event: DDMMYY

3. Based on their clinical record and/or account of drinking provided to you, is their alcohol consumption:

(a) Abstinent? Yes No Don't know

If yes, for how long: DDMMYY

(b) Controlled? Yes No Don't know

If yes, for how long: DDMMYY

4. 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? Yes No

(c) Has the applicant undertaken an opiate treatment programme? Yes No

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 6, Further details.

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

(i) Date of diagnosis: Yes No

(ii) Is it controlled successfully? ☐ ☐

(iii) Is applicant compliant with treatment? ☐ ☐

(iv) Date of last review.

7 Other medical conditions

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

2. Is there any impairment resulting from either a physical or non-physical medical condition which is likely to affect the ability to control a vehicle? Yes No
☐ ☐

If yes, please provide information in section 9, page 6.

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

4. 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 6.

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

If yes, please give details in section 9, page 6.

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

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

If yes, please provide details in section 9, page 6.

8 Medication

Is the applicant currently prescribed any of the following medication:

	Yes	No
(a) Anti-seizure?	☐	☐
(b) Clozapine?	☐	☐
(c) Sulphonylurea or a Glinide?	☐	☐
(d) Insulin?	☐	☐

9 Further details

Do not send any notes not related to fitness to drive.

Use the space below to provide any additional information.

Applicant's full name

Date of birth

9 Further details (continued)	

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

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

[illegible]

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 enquiries into your fitness to drive, we (DVLA) may need you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.

These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.

Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory 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 correspond with medical professionals via electronic channels (email)

Yes ☐ No ☐

Checklist

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

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.