

Medical declaration form

This form must be completed and submitted with the D4 DVLA
Group 2 Medical Examination Report



WEST OXFORDSHIRE
DISTRICT COUNCIL

Applicant Details (To be completed by the Applicant)

Name:	Surname		Date of Birth	DD / MM / YYYY	
	First/Middle				
Address:					
				Postcode	
	Tel. No.	Home		Mobile	
Email:					
GP/Practice Name <i>(where currently registered)</i>					
GP/Practice Address					
		Postcode			
GP/Practice Tel. No.					

Medical Practitioner Details (To be completed by the Doctor carrying out the examination)

Name		Surgery Stamp
Address		
	Postcode:	
Tel. No.		
Email		

In my judgement the applicant is **FIT/UNFIT** *(delete as applicable)* to act as a driver of a Hackney Carriage and/or Private Hire Vehicle in accordance with the DVLA Group 2 Medical Standard

Signature of Medical Practitioner

Date