

MEDICAL ASSESSMENT

ASSOCIATED WITH AN APPLICATION FOR A LICENCE TO DRIVE A
HACKNEY CARRIAGE OR PRIVATE HIRE VEHICLE

Notes for the Applicant

This medical assessment must be carried out by a General Practitioner in the medical practice to which you are registered or any other GP at another practice provided they have access to your full medical records or any GMC (General Medical Council) registered doctor who is licensed to practice in the UK providing the doctor has access to your full medical records..

The vision assessment must be filled in by a doctor or optician/optometrist. Some doctors will be able to fill in both vision and medical assessment section of the report. If your doctor is unable to fully answer all of the questions on the vision assessment you must have it filled in by an optician/optometrist.

IMPORTANT: ASSESSMENTS ARE ONLY VALID FOR 4 MONTHS FROM THE DATE THE DOCTOR AND/OR OPTICIAN OR OPTOMOTRIST SIGNS IT.

Applicant's Details:

Full name: _____ Date of Birth: _____ Age:

Address: _____

Post Code: _____

Contact telephone number: _____

Email: _____

Notes for Applicant

A medical examination will be required if you:

Are a new applicant

Are an existing or lapsed driver who has reached 45 or 55 years of age since you were last licensed?

Are an existing driver whose renewal falls due on your 45th, 55th or 65th birthday?

Have reached 65 years of age (MEDICAL REQUIRED EVERY 3 YEARS THEREAFTER) or:

Has suffered a DVLA Notifiable illness since your last licence.

ALL FEES ARE THE RESPONSIBILITY OF THE APPLICANT

Applicant's consent and declaration

I authorise my General Practitioner(s) to provide the information requested on this form relevant to my fitness to drive a licensed hackney carriage or private hire vehicle to Sefton Council in order to assess my fitness to hold a hackney carriage or private hire driver licence.

I declare that to the best of my knowledge and belief all information given by me to my Doctor in connection with this examination is true.

Signed: _____

Date: _____

General Practitioner

This form must be completed in full by the General Practitioner or Doctor who has reviewed the applicant's full medical records. Please answer all questions and once completed sign the declaration at the end.

Sefton Council's policy on medical fitness requires that hackney carriage and private hire drivers meet Group 2 Medical Standards, as set out in the DVLA publication '*Assessing fitness to drive - a guide for medical professionals*'.

This guide makes reference to current best practice guidance contained in the booklet 'Fitness to Drive' which recommends the medical standard applied by DVLA in relation to bus and lorry drivers should also be applied by local authorities to hackney carriage and private hire drivers.

| | | | |
|-----|---|-----|----|
| (a) | Is the applicant a registered patient of the surgery / medical centre at which you practice as a registered medical practitioner? | YES | NO |
| (b) | Have you reviewed the above applicant's full medical records? If reviewing a printout of the full medical records you must provide the date of printout: | YES | NO |

Section 1

Vision Assessment – to be completed by the GP or Optician/Optomtrist

Please see the current DVLA guidance so that you can decide whether you are able to fully complete the vision assessment at www.gov.uk/current-medical-guidelines-dvla-guidance-for-professionals

| | | | | | |
|----|---|---------------------------|--|---------------------------|--------------------------|
| 1 | Please confirm the scale you are using to express the driver's visual acuities: <input type="checkbox"/> Snellen <input type="checkbox"/> Snellen expressed as a decimal <input type="checkbox"/> LogMAR | | | | |
| | | YES | NO | | |
| 2 | Is the visual acuity at least 6/7.5 in the better eye and at least 6/60 in the other eye? (corrective lenses may be worn to meet this standard) | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Were corrective lenses worn to meet this standard? If Yes please indicate if: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact lenses <input type="checkbox"/> Both | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Uncorrected | | Corrected (using the prescription worn for driving) | | |
| | Right <input type="text"/> | Left <input type="text"/> | Right <input type="text"/> | Left <input type="text"/> | |
| 5 | If glasses (not contact lenses) are worn for driving, is the corrective power greater than +8 dioptries in any meridian of either lens? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | If a correction is worn for driving, is it well tolerated? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 | Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and / or peripheral)? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | Is there diplopia (controlled or uncontrolled)? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 | Does the applicant, on questioning, report symptoms of intolerance to glare and / or impaired contrast sensitivity and / or impaired twilight vision? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 | Does the applicant have any other ophthalmic condition? | | | <input type="checkbox"/> | <input type="checkbox"/> |

If **YES** to questions 7, 8, 9 or 10 please give details in **Section 7**.

| | | |
|--|--|---------------------------------------|
| In relation to Section 1 does the applicant meet the DVLA Group 2 medical standards | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|--|--|---------------------------------------|

If **NO** please indicate reasons why:

If eye examination has been completed by an Optician/Optomtrist please give details below:

| | |
|---------------------------|--|
| Name: | Optician / Optometrist Stamp: <small>FORM WILL NOT BE ACCEPTED WITHOUT AN OFFICIAL STAMP</small> <input style="width: 100%; height: 60px;" type="text"/> |
| Address: | |
| Contact telephone number: | |
| | |

Section 2

NERVOUS SYSTEM

| | | | | YES | NO | | |
|---|---|---|---------------------|--|---------------------------------------|--------------------------|--|
| 1 | Has the applicant had any form of seizure? If YES please answer questions a – f below. | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | a | Has the applicant had more than one attack? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | b | Please give date of first and last attack: | <i>First attack</i> | <i>Last attack</i> | | | |
| | c | Is the applicant currently on anti-epileptic medication? If YES please give details of current medication in section 7 . | | | | | |
| | d | If no longer treated, please give date when treatment ended. | | | | | |
| | e | Has the applicant had a brain scan? If YES please state dates below. | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | MRI: | | CT: | | | | |
| f | Has the applicant had an EEG? If YES please provide date and details in Section 7 | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 2 | Is there a history of blackout or impaired consciousness within the last 5 years? If YES please give dates and details at Section 7 : | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 3 | Does the applicant suffer from narcolepsy? If YES please give dates and details in Section 7 . | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 4 | Is there a history of, or evidence of, any of the conditions listed at a – h below? If NO go to Section 3. | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | If YES please give dates and full details in section 7 . | | | | | | |
| | a | Stroke / TIA (please delete as appropriate) If YES please give date: | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Has there been a full recovery? | | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | b | Sudden and disabling dizziness/vertigo within the last one year with a liability to recur | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | c | Subarachnoid haemorrhage | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | d | Serious traumatic brain injury within the last 10 years | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | e | Any form of brain tumour | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | f | Other brain surgery or abnormality | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | g | Chronic neurological disorders | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| h | Parkinson's disease | | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| In relation to Section 2 does the applicant meet the DVLA Group 2 medical standards? | | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | | |
| If not please indicate reasons why | | | | | | | |

Section 3

DIABETES MELLITUS

| | | YES | NO |
|---|--|--|---------------------------------------|
| 1 | Does the applicant have diabetes mellitus? If NO please complete the declaration at the bottom of the page and then go to Section 4. If YES please answer the following questions. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Is the diabetes managed by:- | <input type="checkbox"/> | <input type="checkbox"/> |
| a | Insulin? If YES please give date started on insulin: | <input type="checkbox"/> | <input type="checkbox"/> |
| b | If treated with insulin, are there at least 3 months of blood glucose readings stored in a memory meter? If NO , please give details in Section 7 | <input type="checkbox"/> | <input type="checkbox"/> |
| c | Other injectable treatments? | <input type="checkbox"/> | <input type="checkbox"/> |
| d | A Sulphonylurea or a Glinide? | <input type="checkbox"/> | <input type="checkbox"/> |
| e | Oral hypoglycaemic agents and diet? If YES please provide details of medication: | <input type="checkbox"/> | <input type="checkbox"/> |
| f | Diet only? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES to any of (a) – (e) above, please give details in Section 7 | | | |
| 3 | a Does the applicant test blood glucose at least twice every day? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b Does the applicant test at times relevant to driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c Does the applicant keep fast acting carbohydrate within easy reach when driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| | d Does the applicant have a clear understanding of diabetes and the necessary precautions for safe driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Is there any evidence of impaired awareness of hypoglycaemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Is there a history of hypoglycaemia in the last 12 months requiring the assistance of another person? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Is there evidence of:- | | |
| a | Loss of visual field? | <input type="checkbox"/> | <input type="checkbox"/> |
| b | Severe peripheral neuropathy, sufficient to impair limb function for safe driving? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES to any or 4 – 6 above, please give details in Section 7 | | | |
| 7 | Has there been any laser treatment or intra-vitreous for retinopathy? If YES please give date(s) of treatment: | <input type="checkbox"/> | <input type="checkbox"/> |
| In relation to Section 3 does the applicant meet the DVLA Group 2 medical standards? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If not please indicate reasons why

Section 4

CARDIAC

4A CORONARY ARTERY DISEASE

| Is there a history of, or evidence of, Coronary Artery Disease? If NO please go to Section 4B. If YES please answer all questions below and give details at Section 7 of the form. | | YES | NO |
|--|--|--------------------------|--------------------------|
| 1 | Acute coronary syndrome including myocardial infarction? If YES please give date(s): | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Coronary artery by-pass graft surgery? If YES please give date(s): | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Coronary Angioplasty (P.C.I.)? If YES please give date of most recent intervention: | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Has the applicant suffered from angina? If YES please give the date of the last known attack: | <input type="checkbox"/> | <input type="checkbox"/> |

4B CARDIA ARRHYTHMIA

| Is there a history of, or evidence of, cardiac arrhythmia? If NO , go to Section 4C If YES please answer all questions below and give details in Section 7 . | | YES | NO |
|---|--|--------------------------|--------------------------|
| 1 | Has there been a significant disturbance of cardiac rhythm? i.e. Sinatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia, in last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Has the arrhythmia been controlled satisfactorily for at least 3 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Has an ICD or biventricular pacemaker (CRST-D type) been implanted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Has a pacemaker been implanted? If YES : | <input type="checkbox"/> | <input type="checkbox"/> |
| a | Please supply date: | | |
| b | Is the applicant free of symptoms that caused the device to be fitted? | <input type="checkbox"/> | <input type="checkbox"/> |
| c | Does the applicant attend a pacemaker clinic regularly? | <input type="checkbox"/> | <input type="checkbox"/> |

| 4C | | PERIPHERAL ARTERIAL DISEASE (EXCLUDING BUERGER'S DISEASE) AORTIC ANEURYSM/DISSECTION | | | | |
|---|---|--|-----------------------------------|------------------------------------|--------------------------|--------------------------|
| Is there a history or evidence of ANY of the conditions listed at 1 – 5 below? If NO go to Section 4D. If YES please answer the questions below and give details in Section 7 | | | | YES | NO | |
| 1 | Peripheral Arterial Disease (excluding Buerger's Disease) | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2 | Does the applicant have claudication? If YES , how long in minutes can the applicant walk at a brisk pace before being symptom limited?: | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3 | Aortic Aneurysm If YES : | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| | a | Site of Aneurysm (please tick): | Thoracic <input type="checkbox"/> | Abdominal <input type="checkbox"/> | | |
| | b | Has it been repaired successfully? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | c | Is the transverse diameter currently >5.5cm? | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | If NO please provide latest measurement: | | Date obtained: | | |
| 4 | Dissection of the Aorta repaired successfully. If YES , please provide details in Section 7 | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5 | Is there history of Marfan's disease? If YES , please provide details in Section 7 | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4D | | VALVULAR/CONGENITAL HEART DISEASE | | | | |
| Is there a history of, or evidence of, valvular/congenital heart disease? | | | | YES | NO | |
| If NO go to Section 4E. If YES please answer all questions below and give details in Section 7 | | | | | | |
| 1 | Is there a history of congenital heart disorder? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2 | Is there a history of heart valve disease? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3 | Is there a history of aortic stenosis? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4 | Is there any history of embolism? (not pulmonary embolism) | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5 | Does the applicant currently have significant symptoms? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6 | Has there been any progression since the last licence application? (if relevant) | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4E | | CARDIAC OTHER | | | | |
| Does the applicant have a history of ANY of the following conditions? If NO go to Section 4F. If YES please answer ALL questions below and give details in Section 7 | | | | YES | NO | |
| a | A history of, or evidence of, heart failure? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| b | Established cardiomyopathy? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| c | Has a left ventricular assist device (LVAD) been implanted? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| d | A heart or heart/lung transplant? | | | <input type="checkbox"/> | <input type="checkbox"/> | |
| e | Untreated atrial myxoma? | | | <input type="checkbox"/> | <input type="checkbox"/> | |

| 4F | | CARDIAC INVESTIGATIONS (This section must be filled in for all applicants) | | |
|--|--|---|---------------------------------|--------------------------------|
| 1 | Has a resting ECG been undertaken? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| | If YES does it show: | | | |
| | a | Pathological Q waves? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b | Left bundle branch block? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c | Right bundle branch block? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Has the exercise ECG been undertaken (or planned)? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | If YES please provide date and give details in Section 7 | | | |
| 3 | Has an echocardiogram been undertaken (or planned)? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | a | If YES please give date and give details in Section 7 | | |
| | b | If undertaken is/was the left ventricular ejection fraction greater than or equal to 40%? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Has a coronary angiogram been undertaken (or planned)? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | If YES please provide date and give details in Section 7 : | | | |
| 5 | Has a 24 hour ECG tape been undertaken (or planned)? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | If YES please provide date and give details in Section 7 | | | |
| 6 | Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)? | | <input type="checkbox"/> | <input type="checkbox"/> |
| | If YES please provide date and give details in Section 7 | | | |
| 4G | | BLOOD PRESSURE (This section must be filled in for all applicants) | | |
| Please record today's blood pressure reading: | | | | |
| Is the applicant on anti-hypertensive treatment? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| If YES please provide three previous readings with dates if available: | | | | |
| 1 | B.P. reading: | Date: | | |
| 2 | B.P. reading: | Date: | | |
| 3 | B.P. reading: | Date: | | |
| In relation to Section 4 does the applicant meet the DVLA Group 2 medical standards? | | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| If not please indicate reasons why | | | | |

Section 5**PSYCHIATRIC ILLNESS**

Is there a history of, or evidence of **ANY** of the conditions listed at 1 – 9 below?
 If **NO** please complete the declaration at the end of the section and go to Section 6.

YES**NO**

If **YES** please answer the following questions and give date(s), prognosis, period of stability and details of medication, dosage and any side effects in **Section 7**. (Please enclose relevant notes). (If applicant remains under specialist clinic(s) please give details in **Section 7**).

| | | | |
|---|---|--|---------------------------------------|
| 1 | Significant psychiatric disorder within the past 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Psychosis or hypomania/mania within the past 3 years, including psychotic depression? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | Dementia or cognitive impairment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Persistent alcohol misuse in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Alcohol dependence in the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | Does the applicant show any evidence of being addicted to the excessive use of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 | Persistent drug misuse in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | Does the applicant show any evidence of being addicted to the excessive use of drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 | Drug dependency in the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| In relation to Section 5 does the applicant meet the DVLA Group 2 medical standards? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If not please indicate reasons why

Section 6

GENERAL

Please answer all questions in this section. If your answer is **YES** to any question please give full details in **Section 7**. Please complete the declaration at the end of the section.

| | | YES | NO | |
|---|--|--|---------------------------------------|--------------------------|
| 1 | Is there currently any functional impairment that is likely to affect control of the vehicle? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2 | Is there a history of bronchogenic carcinoma or other malignant tumour with a significant liability to metastasise cerebrally? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3 | Is there any illness that may cause fatigue or cachexia that affects safe driving? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4 | Is the applicant profoundly deaf? | <input type="checkbox"/> | <input type="checkbox"/> | |
| | If YES is the applicant able to communicate in the event of an emergency by speech or by using a device? (e.g. a textphone) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5 | Does the applicant have a history of liver disease of any origin? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6 | Is there any history of renal failure? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7 | Is there a history of, or evidence of, obstructive sleep apnoea syndrome or any other medical condition causing excessive day time sleepiness? | <input type="checkbox"/> | <input type="checkbox"/> | |
| | If YES please provide details: | | | |
| | a | Date of diagnosis: | | |
| | b | Is it controlled successfully? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c | If YES please state treatment: | | |
| | d | Please state period of control: | | |
| g | Date last seen by consultant: | | | |
| 8 | Does the applicant have severe symptomatic respiratory disease causing chronic hypoxia? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9 | Does any medication currently taken cause the applicant side effects that could affect safe driving? | <input type="checkbox"/> | <input type="checkbox"/> | |
| | If YES please provide details in Section 7 : | | | |
| 10 | Does the applicant have an ophthalmic condition? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11 | Does the applicant have any other medical condition that could affect safe driving? | <input type="checkbox"/> | <input type="checkbox"/> | |
| | If YES please provide details in Section 7 . | | | |
| In relation to Section 6 does the applicant meet the DVLA Group 2 medical standards? | | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |

If not please indicate reasons why

PLEASE ENSURE YOU COMPLETE AND SIGN THE LAST PAGE OF THIS MEDICAL ASSESSMENT

General Practitioner / Doctor Declaration:

Please read the following carefully before completing, signing and dating the declaration.

If you haven't reviewed his/her full medical records then **DO NOT** complete the declaration.

I certify that;

- I am familiar with the current requirements of the **DVLA Group 2 Medical Standards** applied by the DVLA in the current version of 'Assessing fitness to drive - a guide for medical professionals'.
- I have reviewed the applicant's full medical records and that in my opinion nothing therein contradicts or tends to contradict the information given to me by the applicant.
- I have today undertaken a medical examination of the applicant for the purpose of assessing their fitness to act as a driver of a hackney carriage or private hire vehicle under the **DVLA Group 2 Medical Standards**

Having regard to the above I certify that the applicant;

- MEETS (i.e. fit to act as a driver of a licensed vehicle)**
- DOES NOT MEET (i.e. unfit to act as a driver of a licensed vehicle)**

the minimum standards required for the DVLA Group 2 Medical Standards

| | |
|--|---|
| Surgery / Medical Centre Name: | Surgery / Medical Centre Stamp: <small>FORM WILL NOT BE ACCEPTED WITHOUT AN OFFICIAL STAMP</small> |
| Surgery / Medical Centre Address: | |
| GP / Doctor's Name: <small>PLEASE PRINT IN BLOCK CAPITALS</small> | |
| GP / Doctor's G.M.C. Registration No. <small>PLEASE PRINT IN BLOCK CAPITALS</small> | |
| GP's Signature: | Date: |

Date of Issue:

Reference:

e-mail: applications@taxilicensing.sefton.gov.uk