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 *(where currently registered)*				
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	