

Please complete in BLOCK CAPITALS and in black ink.

Section 1

Full name (including title)

Address

Postcode

Date of Birth

 / /

Telephone Number

Section 2

For driving licence purposes you must inform the Licensing Authority if you have had a change in your medical circumstances, or have had any of the following:

(Please ✓ where appropriate)

- | | | | |
|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | An epileptic event (seizure or fit) | <input type="checkbox"/> | A serious problem with confusion |
| <input type="checkbox"/> | Sudden attacks of disabling giddiness, fainting, blackouts or narcolepsy | <input type="checkbox"/> | A major stroke, ie with impaired limb functions, visual field or cognitive defects after 1 month |
| <input type="checkbox"/> | Severe mental handicap | <input type="checkbox"/> | Any type of brain surgery, brain tumour or severe head injury involving hospital in-patient treatment |
| <input type="checkbox"/> | A pacemaker, defibrillator or anti-ventricular tachycardia device fitted | <input type="checkbox"/> | Any severe psychiatric illness or mental disorder |
| <input type="checkbox"/> | A serious heart condition or a heart operation | <input type="checkbox"/> | Continuing/permanent difficulty in the use of arms or legs which affects your ability to control your vehicle safely |
| <input type="checkbox"/> | Angina (heart pain) while driving | <input type="checkbox"/> | Dependence on or misuse of alcohol, illicit drugs or chemical substances in the past three years (Do not include drink driving offences) |
| <input type="checkbox"/> | Diabetes controlled by insulin | <input type="checkbox"/> | Any visual disability affecting either eye (Do not declare short/long sight or colour blindness) |
| <input type="checkbox"/> | Diabetes controlled by tablets | <input type="checkbox"/> | Any other condition, mental or physical, likely to cause the driving of a motor vehicle to be a danger to yourself or the public |
| <input type="checkbox"/> | Any chronic neurological condition eg Parkinson's Disease, Multiple Sclerosis, Motor Neurone Disease | | |
| <input type="checkbox"/> | Meniere's Disease | | |
| <input type="checkbox"/> | A serious problem with memory | | |

If you have ticked any of the boxes, please give a brief description:

