



Mr Alex Thomas Tye
Flat 2b Park Lane
Tilehurst
READING
RG31 5DL

51423



Driver and Vehicle Licensing Agency

Drivers Medical Group

Swansea SA99 1TU

Phone: 0870 600 0301 Fax: 0845 850 0095

Email: eftd@dvla.gsi.gov.uk

Website: www.direct.gov.uk/driverhealth

Driver No: TYE99712041AT9NV

Our Reference: M14780366/Tm8lv11

Date: 10 October 2008

Dear Mr Tye,

ODL DRIVING - GROUP 1 CARS

The Law

Thank you for letting us know about the change in your health. We now need to make enquiries, in the strictest confidence, into your medical fitness to continue to drive Group 1 (car/motorcycle) vehicles.

*Section 94(4)(5)
of the Road
Traffic Act 1988*

What You Need To Do:

- ☐ Complete the medical questionnaire, the consent/declaration form and return to DVLA using the enclosed pre-paid envelope. Upon receipt we may contact your doctor/specialist if required for a medical report.

I should advise you that if you do not fully complete and return the medical questionnaire and consent within 21 days your driving licence may have to be revoked.

*Section 94(8) of
the Road Traffic
Act 1988*

- ☐ You are advised to seek specific advice from your doctors or specialists about driving in the meantime, as it may take some time to complete our enquiries.

What Will Happen Next:

When the enquiries are complete, a decision will be made about your licence and you will be informed of the outcome. The possibilities are:

- Your current Group 1 licence could continue as now
- Your current Group 1 licence could be revoked, but replaced on application by a new one. This may run for one, two or three years; it may also limit the type of vehicles you may drive
- Your licence could indicate that special controls need to be fitted to the vehicles.
- Your current Group 1 licence could be revoked on medical grounds

You may have the right of appeal if your current licence is revoked or if you are offered a short period licence to replace it.



ENVIRONMENTAL AGENCY

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M14780366

An executive agency of the
Department for
Transport

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Please note

If you passed your driving test before 1st January 1997 and your licence has to be revoked/refused or restricted in any way, your entitlement to drive C1/D1 vehicles and minibuses (not for hire or reward) cannot be retained unless you can also meet the higher health standards required for professional drivers. If your licence is to be restricted, further details about this change will be sent to you when our medical enquiries are complete.

If you have any queries, please write to us at the above address or telephone us quoting the reference on this letter.

Rev May 08

Yours sincerely,

Driver Medical Group

Encs:

CONSENT DIZ1 DF



Rev Jul 07
14780366



14780366 CONSENT

Please read the following information carefully and then sign the statement below. This section MUST be completed and must NOT be altered in any way.

Important information about Consent

You will see that we have asked you for your consent for the release of medical reports from your doctors as we may require further information. In addition, as a part of the investigation into your fitness to drive, DVLA may require you to undergo a medical examination or some form of practical assessment.

In these circumstances, those personnel involved will require your background medical details to undertake an appropriate and adequate assessment. Such personnel might include Doctors, Orthoptists at eye clinics or Paramedical Staff at a Driving Assessment centre. Only information relevant to the assessment of your fitness to drive will be released.

In addition, where the circumstances of your case appear exceptional, the relevant medical information would need to be considered by one or more of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

All data held by DVLA is used for internal evaluation of the quality of our services.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release reports/medical information about my condition, relevant to my fitness to drive, to the Secretary of State's medical adviser.

I authorise the Secretary of State to disclose such relevant medical information as may be necessary to the investigation of my fitness to drive, to Doctors, Paramedical staff and Panel members, and to inform my Doctor(s) of the outcome of the case where appropriate.

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: ALEX TYE

Signature: [Signature]

Date: 14/10/08

Electronic Release of Information

DVLA is able to communicate by fax and by e-mail. We can use it to request medical information from your doctor(s). We can also use it to receive relevant medical information sent by your Doctors, Orthoptists or relevant personnel associated with any medical enquiry, medical examination or practical assessment that may be required.

All information held by DVLA is treated with strict confidentiality. E-mails with personal information will be sent by DVLA to medical professionals only where a secure network is available. The security of the electronic transmission of information over the Internet cannot be guaranteed and DVLA cannot accept responsibility for e-mails or faxes sent by others, until they have been received by us. If you do not wish DVLA to communicate in this way or if we are unable to do so, conventional postage methods will be used instead. Should you wish to withdraw your agreement to communicate electronically by fax or e-mail at a later date such a request should be made by you in writing.

Do you agree to DVLA communicating with your Doctors, Orthoptists or relevant personnel by fax and e-mail?

YES ☒ NO ☐



Confidential medical information



14780366 DIZ1



DIZ1

Rev Feb 08

14780366

Medical Fitness to Drive

Please answer all questions and make sure you sign and date the enclosed consent and declaration.

If possible, use **BLACK INK** only.**1 Your details:**Full name: ALEX TYE Date of birth: 4/12/71

Address: _____

Postcode: _____ Contact Phone number: _____

Driver number: _____

***Please tick box if you wish correspondence to be sent to you by fax or e-mail. Your preferred choice will be used wherever possible. Alternatively, conventional post will be used. You must confirm in writing if you wish to cancel the agreement.*

☐ E-mail address: _____ ☐ Fax: _____**2 Your doctor's details:**

Name of your doctor (or medical practice): _____

Address: _____

Postcode: _____ Phone number: _____

E-mail address: _____ Fax: _____

Date you last saw your doctor for this condition: _____

3 Clinic and hospital specialists

Please tick which clinic or hospital specialists you have seen and the most recent date you've seen them within the past 12 months.

	GP	Date(s):	Consultant	Date(s):
Diabetes	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Eye clinic	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Alcohol Problem Clinic	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Drug Problem Clinic	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Neurology or neurosurgery	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Cardiology	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Psychiatry	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Sleep clinic	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
Other (please say which below)	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

If you have ticked any of the above, please give the name of the consultant or doctor and the hospital's address below. If you see a community psychiatric nurse, counsellor, diabetic nurse, eye specialist or opticians, please give their name and the address of the hospital or clinic below.

Reason for going to the clinic or specialists: _____

Name of doctor/consultant/other (see above): _____

Address of the hospital: _____

Hospital record number (if known): _____ Hospital phone number: _____

Reason for going to the clinic or specialists: _____

Name of Doctor/Consultant/Other(see above): _____

Address of the hospital: _____

Hospital record number (if known): _____ Hospital phone number: _____

(Please continue on another sheet if necessary)



If you are unsure of the answers, it would be advisable to discuss the form with your Doctor

1. Have you in the past 12 months, ever experienced attacks of giddiness/dizziness? NO ☐ YES ☐

If NO, go to Q2

If YES, please supply date(s) and answer Q1a and Q1b

First	
Last	
Others	

- a) Do you always have warning of the attacks? NO ☐ YES ☐
- b) Have the attacks of giddiness/dizziness been disabling? NO ☐ YES ☐
2. Have you suffered from any previous bouts of giddiness/dizziness? NO ☐ YES ☐

If YES, please supply approximate date(s) _____

3. Have you been diagnosed with Vertigo /Meniere's disease? NO ☐ YES ☐

If NO, please answer Q3a

- a) Has the cause of the giddiness/dizziness been diagnosed? NO ☐ YES ☐

If YES, please supply diagnosis: _____

4. Are you receiving treatment to control the attacks? NO ☐ YES ☐

If YES, please supply details of treatment: _____

- a) Are the attacks completely controlled? NO ☐ YES ☐
5. Have any of the attacks ever caused a blackout/loss of consciousness/alterd consciousness? NO ☐ YES ☐

If YES, please supply date(s) details and any prescribed medication: _____

6. Please supply the date last seen for this condition by your:

GP _____ Consultant _____