Driver & Vehicle Licensing Agency

Medical examination report
for a Group 2 (bus or lorry) licence

D4

For advice on how to fill in this form, read the leaflet INF4D available at **www.gov.uk/reapply-driving-licence-medical-condition**
Please use black ink when you fill in this report.

Applicants: you must fill in all grey sections of this report. This includes the section below, your full name and date of birth at the end of each page and the declaration on page 8.

Important: This report is only valid for 4 months from date of examination.

Name

Date of birth D D M M Y Y

Address

Postcode

Contact number

Email address

Date first licensed to drive a bus or lorry

D D M M Y Y

If you do not want to receive survey invitations by email from DVLA, please tick box ☐

Your doctor's details (only fill in **if different** from examining doctor's details)

GP's name

Practice address

Postcode

Contact number

Email address

Medical professionals must fill in all green sections on this report.

Important information for doctors carrying out examinations.

Before you fill in this report, you must check the applicant's identity and decide if you are able to fill in the Vision assessment on page 2. If you are unable to do this, you must inform the applicant that they will need to ask an optician or optometrist to fill in the Vision assessment.

Examining medical professional

Name

Has a company employed you or booked you to carry out this examination? Yes ☐ No ☐

If Yes, you **must** give the company's details below.

If 'No', you must give your practice address details below. (Refer to section C of INF4D.)

Company or practice address

Postcode

Company or practice contact number

Company or practice email address

GMC registration number

I can confirm that I have checked the applicant's documents to prove their identity.

Signature of examining doctor

Applicant's weight (kg)

Applicant's height (cm)

Number of alcohol units consumed each week

Units per week

Does the applicant smoke? Yes ☐ No ☐

Do you have access to the applicant's full medical record? Yes ☐ No ☐

Important: Signatures must be provided **at the end of this report**

Driver & Vehicle Licensing Agency

Medical examination report

Vision assessment

To be filled in by an optician, optometrist or doctor

D4

1. Please confirm (✓) the scale you are using to express the applicant's visual acuities.

Snellen ☐ Snellen expressed as a decimal ☐ LogMAR ☐

2. The visual acuity standard for Group 2 driving is at least 6/7.5 in one eye and at least 6/60 in the other.

(a) Please provide uncorrected visual acuities for each eye. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

R ☐ L ☐

(b) Are corrective lenses worn for driving? Yes ☐ No ☐
If No, go to Q3.

If Yes, please provide the visual acuities using the correction worn for driving. Snellen readings with a plus (+) or minus (-) are not acceptable. If 6/7.5, 6/60 standard is not met, the applicant may need further assessment by an optician.

R ☐ L ☐

(c) What kind of corrective lenses are worn to meet this standard?

Glasses ☐ Contact lenses ☐ Both together ☐

(d) If glasses are worn for driving, is the corrective power greater than plus (+)8 dioptres in any meridian of either lens? Yes ☐ No ☐

(e) If correction is worn for driving, is it well tolerated? Yes ☐ No ☐
If No, please give full details in Q7.

3. Is there a history of any medical condition that may affect the applicant's binocular field of vision (central and/or peripheral)? Yes ☐ No ☐

If Yes, please give full details below.

If formal visual field testing is considered necessary, DVLA will commission this at a later date.

4. Is there diplopia? Yes ☐ No ☐

(a) Is it controlled? ☐ ☐

Please indicate below and give full details in Q7.

Patch or glasses with frosted glass ☐ Glasses with/without prism ☐ Other (if other please provide details) ☐

5. Does the applicant report symptoms of any of the following that impairs their ability to drive? Yes ☐ No ☐

Please indicate below and give full details in Q7 below.

(a) Intolerance to glare (causing incapacity rather than discomfort) and/or ☐

(b) Impaired contrast sensitivity and/or ☐

(c) Impaired twilight vision ☐

6. Does the applicant have any other ophthalmic condition affecting their visual acuity or visual field? Yes ☐ No ☐

If Yes, please give full details in Q7 below.

7. Details or additional information

Name of examining doctor, optician or optometrist undertaking vision assessment

I confirm that this report was filled in by me at examination and the applicant's history has been taken into consideration.

Signature of examining doctor, optician or optometrist

Date of signature D D M M Y Y

Please provide your GOC or GMC number

Doctor, optometrist or optician's stamp

Applicant's full name **Date of birth** D D M M Y Y

Please do not detach this page