Driver & Vehicle Licensing Agency

Driver and Vehicle Licensing Agency
Drivers Medical Group
Swansea SA99 1DG
Phone: 0300 790 6806 Fax: 0300 083 0083
Website:
www.gov.uk/driving-medical-conditions

Mr Luke Kenneth C Leighton
Craig Cottage
Glenluce
NEWTON STEWART
DG8 0NR

31829

Our Reference: M48444360/Btm3

Date: 16 April 2024

Dear Mr Leighton,

We have received information from a third party.

We need to make confidential enquiries into your fitness to drive.

What you need to do

Step 1: Complete the enclosed medical questionnaire.	**Step 2:** Complete the enclosed declaration.	**Step 3:** Return both to DVLA using the enclosed envelope.

If you do not respond within 14 days of the date of this letter your driving licence will be revoked (cancelled) or your application refused.

If you do not give us all the information we need, including the **full name, address and telephone number** of your doctor/consultant, this form will be returned to you and this **will result in** delays.

What happens next

When we receive your completed forms we will aim to make a decision within 6 weeks. However, we may need to write to your doctor or consultant, which could take longer. If we do this we will let you know.

If you require further information visit: **www.gov.uk/driving-medical-conditions/what-happens-after-you-tell-dvla** or go to **www.gov.uk** and search for INF94 to view the guide for drivers with a medical condition.

Releasing details of the notifier

Under Data Protection Law, DVLA is not obliged to release any third party information that has been received. We are unable to provide you with details of the person(s) who has notified us.

We have a responsibility to promote road safety and can only act upon information received. We are unable to become involved in any dispute regarding the validity of such information.

Can I continue to drive?

You must be confident that your licence would not be revoked due to any medical condition. If you are unsure if you meet the medical standards for driving, please see your doctor or specialist for advice.

Important information

The Road Traffic Act requires the Secretary of State (in practice the DVLA) to investigate the health of a driver if information is received which suggests that there may be concerns surrounding road safety.

DVLA does not make any medical enquiries without first making the driver aware.

Any medical details provided are given full and careful consideration before a final decision is made about any entitlement to drive. Such decisions are based on the medical evidence alone.

The Law: Section 94(4)(5)(8) of the Road Traffic Act 1988

Rev July 22

Yours sincerely,

Drivers Medical Group

Encs:
AUTHORISE FEP1 DG

Applicant's authorisation

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and sign to confirm the statements below.

Important information about fitness to drive

- As part of the investigation into your fitness to drive, we (DVLA) may require you to have a medical examination and/or some form of practical assessment. If we do, the individuals involved in these will need your background medical details to carry out an appropriate assessment.
- These individuals may include doctors, orthoptists at eye clinics or paramedical staff at a driving assessment centre. We will only share information relevant to the medical assessment of your fitness to drive.
- Also, where the circumstances of your case appear to suggest the need for this, the relevant medical information may need to be considered by one or more of the members of the Secretary of State's Honorary Medical Advisory Panels. The membership of these Panels conforms strictly to the principle of confidentiality.

For information about how we process your data, your rights and who to contact, see our privacy notice at www.gov.uk/dvla/privacy-policy

This section must NOT be altered in any way.

Declaration

I authorise my doctor, specialist or appropriate healthcare professional to disclose medical information or reports about my health condition to the DVLA, on behalf of the Secretary of State for Transport, that is relevant to my fitness to drive.

I understand that the doctor that I authorise, may pass this authorisation to another registered healthcare professional, who will be able to provide information about my medical condition that is relevant to my fitness to drive.

I understand that the Secretary of State may disclose such relevant medical information as is necessary to the investigation of my fitness to drive to doctors and other healthcare professionals such as orthoptists, paramedical staff and the Secretary of State for Transport's Honorary Medical Advisory panel members.

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: ______________________

Signature: ______________________ Date: ______________________

I authorise the Secretary of State to correspond with medical professionals via electronic channels (fax or email) **Yes** ☐ **No** ☐

If you would like to be contacted about your application by email or text message (SMS), please tick the appropriate boxes (below). If not, DVLA will continue to contact you by post.

I authorise a representative of the Secretary of State to contact me via Email or SMS text in relation to this application (Please Tick): Email ☐ Yes ☐ No SMS (Text) ☐ Yes ☐ No

Driver & Vehicle Licensing Agency

Confidential medical information

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FEP1
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PART A: ABOUT YOU

Please complete this form in **BLOCK CAPITAL** letters using **BLACK INK**

Title ________ Full name ______________________________

Full address ______________________________

____

Postcode ____________ Date of birth ____________

NHS number ____________ Driver number ____________
(if known)

Mobile number ____________ Home number ____________
(Optional) *(Optional)*

Email ______________________________
(Optional)

PART B: HEALTHCARE PROFESSIONAL DETAILS

Please provide the details of the GP and Consultant you have seen for this condition

IMPORTANT: Failure to provide your GP/Consultant's full information will result in your case being delayed.

GP DETAILS

Full name ______________________________

Surgery ______________________________

Full address ______________________________

____

Postcode ____________ Phone number ____________

Email ______________________________
(if known)

Date last seen by GP for this condition ____________

CONSULTANT DETAILS

Title ________ Full name ______________________________

Department ______________________________

Full Hospital address ______________________________

____

____

Postcode ____________ Phone number ____________

Email ______________________________
(if known)

Date last seen by consultant for this condition ____________

Driver & Vehicle Licensing Agency

Questionnaire to assess your medical fitness to drive

FEP1
48444360
Rev Oct 21

Epileptic attacks are variably described and involve fits, convulsions or seizures. Epilepsy may also occur only as auras strange feelings or taste, absences or blank spells, limb jerking or twitching. Epileptic episodes may occur when asleep or when awake.

Question 1 **Please indicate diagnosis** (tick relevant box):

a) First ever seizure ☐
Go to Question 2

b) More than one seizure ever or epilepsy ☐
Go to Question 3

c) Dissociative or functional seizures ☐
Go to Question 4

d) Blackout(s) or altered level of consciousness ☐
Go to Question 6

Question 2 First ever seizure

a) Date of seizure *Date* ☐ ☐ ☐

Please give details ______________________

b) If you have been advised by a doctor that your seizure was provoked, please provide details of the circumstances of the seizure and the provoking factor.

____

Please go to Question 5

Question 3 More than one seizure ever or epilepsy

a. Have you ever had two or more seizures in a 5 year period? Yes ☐ No ☐
If Yes, please go to Q3b, if No, please go to Q3c

b. Was the first of these seizures within the last 12 months? Yes ☐ No ☐

c. Please provide the following dates

AWAKE SEIZURES	Day	Month	Year	SLEEP SEIZURES	Day	Month	Year
First awake seizure				First sleep seizure			
Last 2 awake seizures				Last 2 sleep seizures			

Question 3 continued

d) If you have had both awake and sleep attacks, please give the date of the first sleep attack after the last awake attack | | |

e) Have your seizures ever affected your level of consciousness? Yes ☐ No ☐

If Yes, please go to Q3f, if No, please go to Q3g

f) Would your seizures ever have caused difficulty controlling a vehicle? Yes ☐ No ☐

If No to both Q3e or Q3f please give a full description of attack ______

______

g) Was your last seizure a result of advice from your doctor to either stop, reduce or change your epilepsy medication? Yes ☐ No ☐

If you have answered No to Q3g go to Q5

(i) If Yes to Q3g, please give the date you started to reduce/change your medication. *Date* | | |

(ii) Has previously effective medication been restarted? Yes ☐ No ☐

(iii) Please give the date the previous effective medication was restarted. *Date* | | |

(iv) Please give the date of your last seizure prior to the medication withdrawal or reduction of medication seizure. *Date* | | |

Question 4 Dissociative or functional seizures

a) Please give the date of last event *Date* | | |

b) Have any of the events happened whilst driving or as a passenger in a vehicle? Yes ☐ No ☐

Question 5

a) Have you had a seizure as a result of alcohol misuse? Yes ☐ No ☐

If Yes, please give the date(s) and details *Date* | | |

______

b) Have you had a seizure as a result of drug misuse? Yes ☐ No ☐

If Yes, please give the date(s) and details *Date* | | |

______

Question 6 Blackout(s) or altered level of consciousness

		First Event			Last Event		
		DD	MM	YY	DD	MM	YY
a)	Date(s) of blackout or altered level of consciousness						

b) Have you had a pacemaker fitted? Yes [ ] No [ ]

c) Have you had an ICD defibrillator fitted as a result of a blackout? Yes [ ] No [ ]

If Yes, please give the date the device was fitted *Date* [ ]

Question 7

a) Please name all medications you take/have taken for this condition

Medication name	Date started	Date stopped

b) Does the medication make you drowsy or confused whilst driving? Yes [ ] No [ ]

Question 8

Please supply the dates below of any phone, video or face to face consultations for this condition?

	Doctor		Consultant
Date of last contact		Date of last contact	
Date of next contact		Date of next contact	

Please turn over to read and sign the Applicant's Declaration

Applicant's Declaration

You **must** fill in this section and must **not** alter it in any way. Please read the following information carefully and sign to confirm the statements below.

I understand that it is a criminal offence to make a false declaration to get a driving licence and that to do so can lead to prosecution and a maximum penalty of up to two years imprisonment.

Please read the following statements:

- I must inform DVLA of any medical condition which may impact my ability to drive safely.
- I agree to follow the advice of my doctor(s) about treatment for this/these condition(s)
- I will attend, where necessary, appointments to monitor my condition(s)
- I will inform DVLA should I become aware my condition gets worse or I experience any further seizures
- I will inform DVLA if I develop any other medical condition which may impact my ability to drive safely

Do you agree to abide by the above statements? Yes [ ] No [ ]

I confirm that the answers I have given within the medical questionnaire are true. I also agree that I will inform you if, any of the information provided changes.

Name ______________________

Signature ______________________ Date [| |]