Medical Declaration

This is a medical declaration to confirm that I, _____, have no known medical condition that prevents me from being able to safely work and/or participate in activities related to my job. This is a statement of my health as of the date below.

1. Neurological Conditions:

- Epilepsy
- Fits or blackouts
- Syncope (Fainting)
- Repeated attacks of sudden disabling giddiness
- Parkinson's disease
- Narcolepsy or sleep apnoea syndrome
- Stroke (with symptoms lasting longer than one month)
- Recurrent 'mini strokes' or TIAs (Transient Ischaemic Attacks)
- Any type of brain surgery
- Severe head injury involving inpatient treatment
- Brain tumour
- Any other chronic neurological condition
- Serious problem with memory or episodes of confusion
- Severe learning disability

2. Substance Abuse:

- Persistent alcohol abuse or dependency
- Persistent drug abuse or dependency

3. Cardiac Conditions:

- An implanted cardiac pacemaker
- An implanted cardiac defibrillator (ICD)
- Angina and other heart conditions

- Heart operation (for vocational licences)

4. Visual Impairments:

- Glaucoma
- Total loss of sight in one eye
- Any condition affecting both eyes or the remaining eye only (excluding short or long sight or colour blindness)
- Any condition affecting the visual field
- Visual problems affecting either eye (for vocational licences)

5. Metabolic Disorders:

- Diabetes controlled by insulin
- Diabetes controlled by tablets (for vocational licences)

6. Limb Issues:

- Any persistent limb problem that restricts driving to certain types of vehicles or those with adapted controls

7. Mental Health:

- Serious psychiatric illness or mental ill-health

8. Stroke (Specific to Vocational Licences):

- Any form of stroke, including TIAs (Transient Ischaemic Attacks)

I understand that I am responsible for informing my employer or supervisor if I become aware of any medical conditions not previously disclosed herein and that failure to do so may have serious consequences. I will also advise the DLVA should any of the conditions above become applicable to me. I understand that my employer may request a medical examination by a qualified physician, and I agree to comply with such requests.

I have read the above and agree to comply with the requirements as laid out.

Signature: **Printed Name:**

Date: