

**ASSESSMENT APPLICATION FORM (DRIVER)**

Mr / Mrs / Miss / Ms / Dr / Other \_\_\_\_\_

YOUR FULL NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

POSTCODE: \_\_\_\_\_

TEL. NUMBER: \_\_\_\_\_

Can a message be left on this number?      NO       YES

EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

NATIONAL INSURANCE NUMBER: \_\_\_\_\_

*Please fill out the form using BLOCK capitals. If you have difficulty completing this application form, please contact the Mobility Centre for assistance.*

Would you please complete this application form with as much detail as possible. The information you give will help us to plan for your assessment.

**SECTION A – ABOUT YOU**

1. What kind of medical condition do you have?

\_\_\_\_\_

\_\_\_\_\_

2. Please describe how your medical condition affects you.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. How long have you had this medical condition?

\_\_\_\_\_

*If you know the name of your medical condition (e.g. cerebral palsy), please write this here. If you have a non-specific medical condition please give as much information as you can, (e.g. back problems or problems with concentration).*

*Please give as much information as possible. For example, are your limbs affected by restricted movement or lack of strength? Do you easily get tired or have problems with coordination, etc?*

*Please give the date if known.*

4. Can you walk at all?

NO       YES

5. Do you need to use any aids for walking?

Stick       Sticks       Crutches       Walking frame       None

6. Do you have any problems getting into a car?       NO       YES

7. Do you ever use a wheelchair / scooter at home or outdoors?

NO       YES

If NO, please move on to question 9.

If YES, please indicate what type of wheelchair / scooter you use and for what purpose

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8. If you use a wheelchair, can you transfer into a vehicle without help from others?

NO       YES

9. Are you in receipt of the Higher Rate Mobility Component of the Disability Living Allowance **or** Personal Independence Payment?

NO       YES

**or** the Mobility Supplement of the War Pension **or** Armed Forces Independence Payment?

NO       YES

If YES, how long is the award for? \_\_\_\_\_

## SECTION B – YOUR ASSESSMENT

1. What do you hope to gain from your assessment?

2. What type of difficulties are you experiencing as a driver?

3. Please write below any dates over the next three months when you **cannot** come for an assessment.

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4. Occasionally people cancel appointments at short notice. Would you like us to tell you about last minute cancellations if it would mean an earlier appointment?

NO       YES

5. Do you have any other special requirements during your visit?

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6. Do you require the services of an interpreter?

YES Which language? \_\_\_\_\_  
 YES British Sign Language

7. Would you like us to send you a list of accommodation in and around our location?

NO       YES

## SECTION C – DRIVING LICENCE DETAILS

1. Do you have a valid driving licence?

- Yes - full licence, currently driving
- Yes - full licence, not driving at present
- Yes - provisional, never driven
- Yes - provisional, having / had tuition
- Yes - Provisional Disability Assessment Licence
- No – please contact the Mobility Centre for advice

*Tick the box that describes your current situation.*

2. Please give the following details about your driving licence

Your driving licence number: \_\_\_\_\_

Licence valid from: \_\_\_\_\_ valid to: \_\_\_\_\_

3. Has your driving licence ever been revoked by the DVLA?

- NO
- YES – If YES what date was it revoked? \_\_\_\_\_

*Please note that it is YOUR responsibility to inform the DVLA if you have a disability or health problem that is likely to affect your driving.*

4. What type of vehicle do you drive at present?

- Automatic transmission.
- Manual transmission.

Make / model: \_\_\_\_\_

5. Is your vehicle adapted in any way?  NO  YES  
If YES, please give details:

6. Does the DVLA know about your present condition or disability?

- NO  
 YES - IF YES, when did you inform the DVLA? \_\_\_\_\_

7. Has a Doctor advised you against driving?

- NO  
 YES - IF YES, it is advisable to ensure that your Doctor is happy for you to attend.

8. Are you able to read a vehicle number plate at the required distance of 20 metres (with corrective lenses if required)? It is advisable that you check you can meet this requirement prior to attending for a driving assessment.

- NO  
 YES

#### SECTION D - PAYMENT

Although your assessment is subsidised, there is an administration fee of **£93.00**

**Please enclose payment with this application form.**

We can accept cheques and postal orders.

Cheques should be made payable to: **Wales Mobility and Driving Assessment Service.**

**If you would like to pay by credit/debit card please contact the Mobility Centre on 01745 58 48 58**

#### SECTION E – YOUR CONSENT

1. To help us plan our services, could you tell us how you heard about the Assessment Service?

2. As part of our aim to reach everyone in the community, it would help us if you could tick one of the following.

White	Mixed	Asian or Asian British	Black or Black British	Chinese or other ethnic group
British	White and Black Caribbean	Indian	Caribbean	Chinese
Any other white background	White and Black African	Pakistani	African	Any other
Irish	White and Asian	Bangladeshi	Any other Black background	
	Any other Mixed background	Any other Asian background		

**CONSENT** This section **MUST** be completed and must **NOT** be altered in any way.

On occasions, the Mobility Centre have health professionals or Approved Driving Instructors who wish to observe an assessment process for training purposes. If you do not wish to have an observer attend your assessment, please tick this box.

Please sign below to indicate your consent to undertake a driver assessment with The Wales Mobility and Driving Assessment Service, during which you will be given advice and information regarding your ability to drive. Your signature will also indicate that the information you have given in this application form is correct.

On occasions it can be in your interest if we share the findings of your assessment with a third party such as a family member, Doctor, support worker or specialist involved in your care. By listing below details of the people we can discuss your case with you are indicating your consent for us to discuss the findings of your assessment with these parties.

We can only discuss your assessment outcome with other parties if permission is given by you. Please indicate you consent by listing below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

If you give permission for us to share the findings of your assessment with a third party please give contact details below:

General Practitioner or third party.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing on behalf of the applicant please could you indicate your relationship to them eg: relative, legal guardian etc.

**Thank you for taking time to complete this application form. We will aim to let you know the date of your assessment within 2 weeks of receiving this form.**