



Driver Assessment Application

1. Your Details

Mr Mrs Ms Miss

Forename(s):

Surname:

Address:

Postcode:

Email Address:

Telephone:

Date of birth:

Name and contact telephone in case of emergency:

2. How did you hear about us?

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> Been before | <input type="checkbox"/> Other Mobility Centres | <input type="checkbox"/> DVS | <input type="checkbox"/> Friend / Relative |
| <input type="checkbox"/> Driving Instructor | <input type="checkbox"/> Publications / Media | <input type="checkbox"/> Charity | <input type="checkbox"/> Hospital Doctor |
| <input type="checkbox"/> Garage | <input type="checkbox"/> Therapist - H&SS | <input type="checkbox"/> Web Site | <input type="checkbox"/> GP |
| <input type="checkbox"/> Social Services | <input type="checkbox"/> Disability Group | <input type="checkbox"/> Solicitors | <input type="checkbox"/> Other |

3. Licence Details

Do you still hold a valid licence?

Yes No

What sort of licence do you hold?

Full Provisional None

Driving Licence Number:

Expiry Date: (DD/MM/YYYY)

Groups licensed to drive: (e.g. LGV, PCV, Motorcycle, etc)

It may be necessary, in some circumstances, to contact the DVS for clarification regarding your driving status

Number of years driving experience:

What type of car do you feel you could drive?

Automatic Manual Not Sure

What type of car did you drive?

4. Mobility Details

Are there any restrictions on how far you can walk?

Yes No

Do you require any aids when walking?

Yes No

Do you use a wheelchair?

Yes No

If yes, can you transfer unaided into a car seat?

Yes No

Are there any restrictions related to your disability recorded on your licence?

Yes No

If yes, please give details:

Have you informed the Parish you reside in of your disability?

Yes No

Has the Parish/GP asked you to stop driving at this time?

Yes No

Did you decide to return your licence to the Parish at any time?

Yes No

If yes, why was this?

5. Nature of disability or problem(s)

In your own words please specify your disability or problems:

Are you currently on any medication?

Yes No

If yes, which medication(s)?

6. Comments

If you have any comments or feedback please write them below:

If you need more space, turn the page over and continue on the back.

7. Membership and signature

Driving For The Disabled would like to keep your name and address on our database in order to keep you informed of upcoming events and annual meetings. The information held will not be released to anyone outside of the organization.

Would you like to become a member of Driving for the Disabled?

Yes No

Do you give permission for Driving for the Disabled to hold your information on file?

Yes No

Your signature: _____

Today's date: _____

Please sign and return this form to:

K Mauger-Dorrington
L' Heritage Cottage
La Rue des Ifs, Trinity
Jersey JE35FT



Request for consent to obtain medical information

I hereby give my consent for my General Practitioner / Healthcare Professional to be contacted for any further medical information relevant to this assessment. I understand that I may be asked to undergo further assessments from the medical team. This will be treated in strict confidence. I also understand that the result of my assessment will be sent to my Parish Constable and he/she will have the final decision regarding my suitability to drive.

Please print your name: _____

Your signature: _____

Today's Date: _____

Please provide contact details for your General Practitioner or Healthcare Professional, so we can begin the assessment.

GP/Consultant:

Address 1:

Address 2:

Postcode:

Telephone:

Please sign and return this form to:

K Mauger-Dorrington
L' Heritage Cottage
La Rue des Ifs, Trinity
Jersey JE35FT