MEDICAL FORM

IMPORTANT NOTES TO APPLICANT

1. Please complete sections 1, 2 & 3 of this form. PLEASE – Print clearly
   These sections must be done prior to visiting the Medical Examiner (Doctor)
2. Prior to your visit to the Medical Examiner you should telephone for an appointment
3. Sections 1, 2, 3 & 4 of this form are retained by your Medical Examiner for their records.
4. ONLY Section 5 is to be returned with your licence paperwork to your State Council Licence Officer

SECTION 1 – TO BE COMPLETED BY APPLICANT

SURNAME:			
GIVEN NAMES:			
RESIDENTIAL ADDRESS:			
STATE:		POST CODE:	
POSTAL ADDRESS: (If different from residential address)			
STATE:		POST CODE:	
PHONE (HOME):		PHONE (WORK):	
MOBILE:		FAX:	
EMAIL:			
OCCUPATION:			
DATE OF BIRTH:			

SECTION 2 – TO BE COMPLETED BY APPLICANT

	STATEMENT BY APPLICANT *Please tick*	YES	NO
A	Do you at present have any disease or disability?		

HAVE YOU EVER SUFFERED FROM:

B	Anxiety State. Depression or any nervous or mental disorder?		
C	Headaches - recurrent or severe?		
D	Epilepsy, fits, turns or blackouts?		
E	Fainting, giddiness or dizziness?		
F	Head injury or concussion?		
G	Tuberculosis, Bronchitis, Asthma or Pneumonia?		
H	Rheumatic Fever or heart disease?		
I	Indigestion, gastric or duodenal ulcer?		
J	Kidney or bladder trouble?		
K	Diabetes?		
L	Anemia or other blood disorder?		
M	Jaundice, hepatitis or glandular fever?		
N	Noises in ear, earache or discharge?		
O	Chronic sinus trouble?		
P	Any surgical operation?		
Q	Any fracture or broken bones?		
R	Any illness or injury not mentioned?		
S	Wear glasses or contact lenses?		
T	Take any tablets, injections or other form of medication?		

For each 'Yes' answer, please provide full details (including dates where applicable) in the space below:

Note: if there is not enough space here, please attach an additional page with the details.

SECTION 3 - DECLARATION TO BE COMPLETED BY APPLICANT

I, _____ hereby declare that I have carefully considered my answers to the questions above, and that to the best of my knowledge that they are complete and correct and I have not withheld any information or made any misleading statement.

Furthermore, I declare that, should I sustain any accident or injury, or should any of the above answers not continue to apply throughout the currency of any licence issued to me based on this medical examination, I agree to immediately surrender such licence to the APBA and agree to submit myself for a further medical examination.

I authorise the Medical Assessor, or his/her representative to obtain relevant clinical records, X-rays and pathology reports from any hospital or medical practitioner that I have previously attended.

If a female applicant, I agree to abstain from exercising the privileges of this licence in the last four (4) months of pregnancy.

Date:		**Signature of Applicant:**	
Witness or Medical Examiner:			

SECTION 4

CONFIDENTIAL REPORT BY MEDICAL EXAMINER

AGE	HEIGHT	WEIGHT

PULSE RATE	BLOOD PRESSURE

	Tick Answers			Tick Answers	
	Normal	Abnormal		Normal	Abnormal
CARDIOVASCULAR SYSTEM			**CENTRAL NERVOUS SYSTEM**		
Heart Size			Intellect		
Heart Sounds			Deep Reflexes		
Murmurs			Coordination		
ECG (if required)					
RESPIRATORY SYSTEM			**LIMBS**		
Air Entry			Deformity		
Breath Sounds			Range of Joint Movement		
Accompaniments					
ABDOMEN			**URINE**		
Viscera			Protein		
Hernia Orifices			Glucose		
ENT & VESTIBULAR SYSTEMS			**VISUAL SYSTEM**		
Tympana			Eyes – any Abnormality		
Nystagmus			General Inspection		
Sharpened Romberg			Eye Movements, cover test		
			Fields, confrontation test		

VISUAL ACTIVITY

	Right	Left
NATURAL SIGHT	**6 /**	**6 /**

	Right	Left
WITH CORRECTION SPECTACLES / CONTACT LENSES	**6 /**	**6 /**

EXAMINERS COMMENTS

On history

On examination

SECTION 5

ONLY THIS PAGE IS TO BE RETURNED TO THE YOUR STATE COUNCIL LICENCE OFFICER

MEDICAL EXAMINATION RECORD

PLEASE PRINT CLEARLY WITH A BLACK OR BLUE PEN

APPLICANT DETAILS

SURNAME:	
GIVEN NAMES:	
RESIDENTIAL ADDRESS:	
DATE OF BIRTH:	

STATEMENT BY EXAMINER

Today, I have examined _____

and find this applicant FIT / UNFIT to participate in Power Boat Racing.

Name of Medical Examiner *(please print)*: _____

_____ _____

Signature of Medical Examiner **Date of Medical Examination**

To enable the applicant to be given a licence, it is required that the Medical Examiner's stamp be placed over his/her signature. Failure to do this will result in the non-acceptance, by the Australian Power Boat Association, of this application.

APBA OFFICE USE ONLY

Date:	
Licence No.:	
Race No.:	
Next medical due:	