

IMPORTANT NOTES TO APPLICANT

1. Please complete sections 1, 2 & 3 of this form. Print clearly with a black ballpoint pen
These sections must be complete 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. Section 5 is returned with your licence paperwork to your Member 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		<i>Please tick</i>	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

EXAMINATION 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	
Nystagmu		General Inspection	
Sharpened Rhomberg		Eye Movements, cover test	
		Fields, confrontation test	

VISUAL ACTIVITY

NATURAL SIGHT	Right	Left
	6 /	6 /

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

EXAMINERS COMMENTS

On history

On examination

SECTION 5

MEDICAL EXAMINATION RECORD

THIS PAGE ONLY IS TO BE RETURNED TO YOUR APBA MEMBER COUNCIL

PLEASE PRINT CLEARLY WITH A BLACK BALL POINT PEN

APPLICANT DETAILS

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

STATEMENT BY MEDICAL 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 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:	