



APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE PHYSICAL EXAMINATION

<p>APPLICANT'S FULL NAME AND ADDRESS</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>FAA TYPE CLASS III Physical Examination</p> <p>INSTRUCTIONS FOR MEDICAL PHYSICIAN AND APPLICANT</p> <ol style="list-style-type: none"> 1. This examination is for a Race Boat competition license. 2. Have the applicant complete medical history information. 3. Record your medical findings. 4. Return completed form to applicant.
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MEDICAL HISTORY (This should include any and all changes within the last two years.)

HAVE YOU EVER HAD OR HAVE NOW ANY OF THE FOLLOWING: *(For each "yes" checked, describe and date condition in remarks)*

Y	N	Condition	Y	N	Condition	Y	N	Condition	Y	N	Condition
		a. Frequent or severe headaches			g. Heart trouble/Pacemaker			m. Nervous trouble of any sort			s. Medical rejection from or for military service
		b. Dizziness or fainting spells			h. High or low blood pressure			n. Any drug or narcotic habit			t. Rejection for life insurance
		c. Unconsciousness for any reason			i. Stomach trouble			o. Excessive drinking habit			u. Admission to hospital
		d. Eye trouble except glasses			j. Kidney stone or blood in urine			p. Attempted suicide			v. D.U.I.
		e. Asthma/Hay fever			k. Sugar or albumin in urine/Diabetes			q. Motion sickness requiring drugs			w. Alcohol/Drug convictions
		f. History of fractures			l. Epilepsy or fits/Seizures			r. Military medical discharge			x. Other illnesses

REMARKS: *(For each "yes" checked, describe and date condition)*

MEDICAL TREATMENT WITHIN THE LAST 5 YEARS

DATE	NAME AND ADDRESS OF PHYSICIAN CONSULTED	REASON

<p>APPLICANT'S CERTIFICATION & AGREEMENT: I hereby certify that all statements and answers provided by me in this examination form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any NJBA certificate or license to me I understand and agree that if I give any untruthful information on this form, I forfeit any and all privileges to participate in any and every aspect of the sport of drag racing.</p>	
<p>Signature of applicant</p>	<p>Date</p>

Applicant's Name			AGE	D.O.B.	Ht	Wt	HAIR	EYES	SEX	
Report of Medical examination (Please type or print)										
NO RM AL	CHECK EACH IN APPROPRIATE COLUMN					ABNO RMAL	NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.			
	1. Head, face neck and scalp									
	2. Nose									
	3. Sinuses									
	4. Mouth and throat									
	5. Ears, general									
	6. Drums									
	7. Eyes, general (visual acuity under items 27, 28 & 29)									
	8. Ophthalmoscope									
	9. Pupil									
	10. Ocular motility [associated parallel movement, mystiques]									
	11. Lungs and chest (breast exam only if clinically indicated or requested)									
	12. Heart (Primordial activity, rhythm, sounds and murmurs)									
	13. Vascular system (pulse, amplitude and character; arms, legs, other)									
	14. Abdomen and viscera (including hernia)									
	15. Anus and rectum (digital exam only if clinically indicated or requested)									
	16. Endocrine system									
	17. G-u system (pelvic exam only if clinically indicated or requested)									
	18. Upper and lower extremities (strength and range of motion)									
	19. Spine, other Musculoskeletal									
	20. Identifying body marks, scars, tattoos									
	21. Skin and Lymphatic									
	22. Neurological (tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)									
	23. Psychiatric (Appearance, behavior, mood, communication and memory)									
	24. General systemic									
25. BLOOD PRESSURE (setting MM mercury)			26. HEART RATE		27 FIELD OF VISION (peripheral)		28 Distant vision (must have <u>both</u> finding)			
Systolic	Diastolic		Resting pulse	Normal ___ Abnormal ___	Right Eye		Uncorrected20/		Corrected20/	
				Corrective lens to Drive No ___ Yes ___	Left Eye		20/		20/	
					Both Eyes		20/		20/	
Urinalysis (If sugar is positive see #31.)				Blood Sugar Test (Both Fasting & 2 Hour Post Prandial, required Only if sugar is found in urine. No S.I Units)						
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Albumin <input type="checkbox"/> No <input type="checkbox"/> Yes		Sugar <input type="checkbox"/> No <input type="checkbox"/> Yes	Fasting	2-hours P.P.	Comments				
32. Other Tests					33. Disqualifying Defects/Limitations					
34. Comments On History And Findings, Recommendations (Include Specific Medical Condition And Medications Currently Prescribed)										
35. Ekg (Current Ekg Required At Age 55 And Older, Does Not Reflect Any Abnormalities That Would Preclude The Patient From Racing.										
35a. Ekg (date)			<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Heart trouble within 2 years, must submit recent Ekg and cardiologist release							
MM	DD	YY								
36. Please check one <input type="checkbox"/> Physically acceptable <input type="checkbox"/> Further Evaluation Required										
37. Medical Physician/ d.o. declaration: I hereby certify that I personally examine the applicant named this medical report and that this report and any attachment embodies my findings completely and correctly. I have also reviewed the medical history on reverse side of form.										
Date of examination			Medical Physician(MD/Do Only) Signature			Medical Physician (MD/ Do only) Name, Title, Address & Phone No. (Type or print)				
			State License #			Phone()		Fax ()		