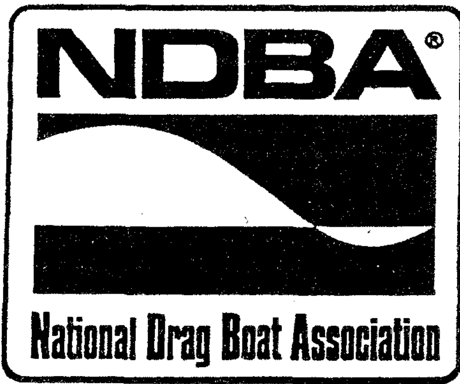

APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE

PHYSICAL EXAMINATION INSTRUCTIONS

1. Page one to be filled out by the driver.
2. Page two to be filled out by the physician.
3. This examination is for a race boat driver's competition license.
4. Both pages must be completed in full.
5. Copy of receipt or confirmation of exam on Doctors letterhead must accompany this form.

PLEASE PRINT

NAME______________________________

ADDRESS______________________________

CITY______________________________

STATE______________ ZIP______________

HEIGHT______________ WEIGHT______________

HAIR COLOR______________ EYES______________

DATE OF BIRTH______________________________

AGE______________ SEX______________

Division 1 ADBA ☐ Division 2 CSDBA ☐

Division 3 SDBA ☐ Division 4 SLDBA ☐

New License ☐ Renewal ☐

Do you have a motor vehicle license? YES ☐ NO ☐

Are there any restrictions? YES ☐ NO ☐

If yes explain______________________________

Do you wear ? Glasses ☐ Contacts ☐

MEDICAL HISTORY

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

Y N	CONDITION	Y N	CONDITION	Y N	CONDITION	Y N	CONDITION
☐☐	a. Frequent or severe headaches	☐☐	g. Heart trouble	☐☐	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. Record of traffic convictions
☐☐	e. Hay fever	☐☐	k. Sugar or albumin in urine	☐☐	q. Motion sickness requiring drugs	☐☐	w. Record of other convictions
☐☐	f. Asthma	☐☐	l. Epilepsy or fits	☐☐	r. Military medical discharge	☐☐	x. Other illnesses

REMARKS *(If no changes since last report, so state)*

MEDICAL TREATMENT WITHIN PAST 5 YEARS

DATE	NAME AND ADDRESS OF PHYSICIAN CONSULTED	REASON

APPLICANT'S DECLARATION: *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 condsidered part of the basis for issuance of any NDBA Certificate to me.*

SIGNATURE OF APPLICANT *(In ink)* DATE

REPORT OF MEDICAL EXAMINATION *(Please type)*

NOR-MAL	CHECK EACH ITEM IN APPROPRIATE COLUMN (Enter NE if not evaluated)	AB NOR MAL	NOTES: Describe every abnormality in detail, enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.
	25. Head, face, neck and scalp		
	26. Nose		
	27. Sinuses		
	28. Mouth and throat		
	29. Ears, general *(Internal & external canals)*		
	30. Drums *(Perforation)*		
	31. Eyes, general *(Visual acuity under 50 & 51)*		
	32. Opthalmoscopic		
	33. Pupils *(Equality and reaction)*		
	34. Ocular motility *(Associated parallel movement, mystagmus)*		
	35. Lungs and chest *(Including breasts)*		
	36. Heart *(Thrust, size, rhythm, sounds)*		
	37. Vascular system		
	38. Abdomen and viscera *(Including hernia)*		
	39. Anus and rectum *(Hemorrhoids, fistula, prostate)*		
	40. Endocrine system		
	41. G - U system		
	42. Upper and lower extremities *(Strength, range of motion)*		
	43. Spine, other musculoskeletal		
	44. Identifying body marks, scars, tattoos		
	45. Skin and lymphatics		
	46. Neurologic *(Tendon reflexes, equilibrium, senses, coordination)*		
	47. Psychiatric *(Specify any personality deveiation)*		
	48. General systemic		

INTRAOCULAR TENSION

		RIGHT EYE	LEFT EYE
	TACTILE		
	TONOMETRIC		

DISTANT VISION *(Standard test types only)* / **NEAR VISION** *(Use linear values)*

	DISTANT		NEAR	
RIGHT EYE	20/	CORRECTED TO 20/	20/	CORRECTED TO 20/
LEFT EYE	20/	CORRECTED TO 20/	20/	CORRECTED TO 20/
BOTH EYES	20/	CORRECTED TO 20/	20/	CORRECTED TO 20/

FIELD OF VISION

RIGHT EYE LEFT EYE

COLOR VISION *(Test used, number of plates missed)*

BLOOD PRESSURE

RECUMBENT MM MERCURY	SYSTOLIC	DIASTOLIC

PULSE *(Wrist)*

RESTING	AFTER EXERCISE	2 MINUTES AFTER EXERCISE

URINALYSIS

ALBUMEN	SUGAR

OTHER TESTS

COMMENTS ON HISTORY AND FINDINGS, RECOMMENDATIONS *(Attach all consults, ECGs, X-rays, etc. to this report before mailing)*

APPLICANT'S NAME

	NORMAL, HEALTHY
	FURTHER EVALUATION REQUIRED

DISQUALIFYING DEFECTS *(List by item no.)*

MEDICAL EXAMINER'S DECLARATION: *I hereby certify that I personally examined the applicant named on this medical examinaiton report, and that this report and any attachment embodies my findings completely and correctly.*

DATE OF EXAMINATION	MEDICAL EXAMINER'S NAME AND ADDRESS *(Type or print)*	MEDICAL EXAMINER'S SIGNATURE
	PHONE # (__________)__________________________	