APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE PHYSICAL EXAMINATION

APPLICANT'S FULL NAME AND ADDRESS

Name: ____________________

Address: ____________________

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FAA TYPE CLASS III Physical Examination

INSTRUCTIONS FOR MEDICAL PHYSICIAN AND APPLICANT

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.

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

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.

Signature of applicant	Date

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 reflexes0, equilibrium, senses, cranial nerves, coordination, etc.)		
	23. Psychiatric (Appearance, behavior, mood, communication and memory)		
	24. General systemic		

25. BLOOD PRESURE (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)		
☐ Normal ☐ Abnormal	Albumin ☐ No ☐ Yes	Sugar ☐ No ☐ 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)			
MM	DD	YY	☐ Normal ☐ Abnormal Heart trouble within 2 years, must submit recent Ekg and cardiologist release

36. Please check one ☐ Physically acceptable
☐ Further Evalution 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 ( )