



MEDICAL EXAMINATION FORM

IMPORTANT NOTES TO APPLICANT

1. Please complete Sections 1 & 2 of this Form. Print clearly with black pen. 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 of this Form are retained by the Medical Examiner for their records.
4. Section 4 is to be returned to NWSRA Region V Australia.

SECTION 1 TO BE COMPLETED BY APPLICANT

SURNAME:		
GIVEN NAMES:		
RESIDENTIAL ADDRESS:		
	State	P/Code
POSTAL ADDRESS:		
	State	P/Code
PHONE:		
Work:	Home:	Mobile:
OCCUPATION:		

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)	TB, 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 tables, injections or other form of medication?		

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

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

SECTION 3
TO BE COMPLETED BY APPLICANT

“ DECLARATION ”

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 on the basis of this Medical Examination, I agree to immediately surrender such licence to NWSRA Region V Australia and agree to submit myself for a further Medical Examination. I authorise the Medical Assessor, or his/her representative of NWSRA Region V Australia 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 Application

.....
Witness – Medical Examiner

SECTION 3
CONFIDENTIAL REPORT BY MEDICAL EXAMINER

AGE	HEIGHT	WEIGHT

PULSE RATE	BLOOD PRESSURE

	Tick Answers	
	Norm	Abnormal
CARDIVASCULAR SYSTEM		
Heart Size		
Heart Sounds		
Murmurs		
ECG (if required)		
RESPIRATORY SYSTEM		
Air Entry		
Breath Sounds		
Accompaniments		
ABDOMEN		
Viscera		
Hernia orifices		
ENT & VESTIBULAR SYSTEMS		
Tympana		
Nystagmu		
Sharpened Rhomberg		

	Tick Answers	
	Norm	Abnormal
CENTRAL NERVOUS SYSTEM		
Intellect		
Deep reflexes		
Co-ordination		
LIMBS		
Deformity		
Range of joint movement		
URINE		
Protein		
Glucose		
VISUAL SYSTEM		
Eyes – any abnormality		
General Inspection		
Eye movements, cover test		
Fields, Confrontation test		

VISULAR ACTIVITY

NATURAL SIGHT	RIGHT	LEFT
	6/	6/

WITH CORRECTIONAL SPECTACLES/CONTACT LENSES	RIGHT	LEFT
	6/	6/

SECTION 3 (cont'd)

MEDICAL CLEARANCE TYPES

- 'A' (Unrestricted) Applicant to be re-examined every two (2) years
- 'B' (Restricted) Applicant to be re-examined yearly

EXAMINER'S COMMENTS

On History

On examination

SECTION 4

MEDICAL EXAMINATION FORM

(This Page **ONLY** to be returned to NWSRA Region V Australia)

APPLICANT DETAILS		
SURNAME:		
GIVEN NAMES:		
ADDRESS:		
	State	P/Code
DATE OF BIRTH:		

STATEMENT BY DOCTOR / EXAMINER:

Today I have examined and find this Applicant **FIT / UNFIT** (please circle) to participate in water ski racing.

This applicant is assessed as being suitable for a **(Please Circle A or B)**

A (every 2 years) medical clearance **Expires 30/6/**

B (yearly) medical clearance **Expires 30/6/**

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 NWSRA Region V Australia, of this application.*