



ATTENTION!

**ALL YELLOW HIGHLIGHTED AREAS
MUST BE COMPLETED AND SIGNED BY A
MEDICAL DOCTOR OR D.O. OR YOUR
MEDICAL FORM IS INVALID.**

**THIS MEANS YOU CANNOT DRIVE
UNTIL COMPLETE!**

**ALL LIGHT BLUE HIGHLIGHTED AREAS MUST
BE COMPLETED BY YOU.**

**BEFORE YOU LEAVE YOUR DOCTOR'S
OFFICE --- PLEASE MAKE SURE HE OR
SHE HAS COMPLETED **ALL** AREAS OF
THIS FORM!**

**If you have any questions, please call
us 866-480-7223!
(Outside US - 352-336-8111)**

APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE



PHYSICAL EXAMINATION

INSTRUCTIONS FOR MEDICAL PHYSICIAN AND APPLICANT

1. This medical certificate must be completed by an **M.D. or D.O. only.**
2. This examination is for a driver's racing competition license.
3. **M.D. or D.O. must complete medical history information.**
4. Record your medical findings.
5. Application will be returned if **any** information is incomplete.
6. Reverse side of this form to be completed in **full**. If unable to complete or obtain any findings, refer patient to a second physician and attach any supplements.
7. **M.D. or D.O. must sign reverse side of this form.**
8. Application and attachments **must** be in English.
9. EKG required at age 55 and older, copy must be attached.
10. Attach all findings, consults, ECG, EKG, x-rays to this report.
11. Return completed **original** form to applicant. **Copies not accepted.**
12. LICENSE WILL BE VALID FOR TWO YEARS FROM THE MONTH OF THE PHYSICAL. (TOP FUEL AND FUNNY CAR VALID FOR ONE YEAR; ANNUAL RENEWAL)
13. Any matter, including without limitation any conditions or medications, in this examination may be referred to an NHRA medical consultant for review, and may be cause for rejection.

APPLICANT'S FULL NAME AND ADDRESS

Name: _____

Address: _____

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*)

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	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 (If yes, circle one)			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 INCLUDING SURGICAL PROCEDURES WITHIN THE LAST 5 YEARS (continue on additional page if necessary)

DATE	NAME AND ADDRESS OF PHYSICIAN CONSULTED	REASON

APPLICANT'S CERTIFICATION, AFFIRMATION & AGREEMENT: I hereby certify that all statements and answers provided by me in this examination form are true and complete, and I agree that they are to be considered part of the basis for issuance of any NHRA 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. I affirm that I have read, understand and agree to be bound by all NHRA rules, regulations and agreements including, but not limited to, those contained in the applicable NHRA Rulebook, with specific reference, but not limited to the rules regulations and agreements contained in the Administration Procedures and Appeals Section of the applicable Rulebook which are incorporated herein by reference. I know that the NHRA Rulebook, including amendments, is available to me online. I agree that participation in any and every aspect of the sport of drag racing is a privilege, not a right, and I wish to participate in accordance with all of the foregoing. I further affirm all of the following: Drag racing is a dangerous sport. There is no such thing as a guaranteed safe drag race. Drag racing always carries with it the risk of serious injury or death in any number of ways. This risk will always exist no matter how much everyone connected with drag racing tries to make our sport safer. Although NHRA works to promote and enhance the safety of the sport, there are no guarantees that such safety measures will guarantee or ensure my safety. I as the participant always have the responsibility for my own safety, and by participating in drag racing, I am accepting all risks of injury, whether due to negligence, vehicle failure, or otherwise. If at any time I do not accept these risks, I will not participate in drag racing. I understand the NHRA Competition Number is issued solely for participation in drag racing on NHRA Member Tracks.

SIGNATURE OF APPLICANT (In ink)

DATE

AGE	DATE OF BIRTH	HEIGHT	WEIGHT	HAIR	EYES	SEX
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APPLICANT'S NAME _____

REPORT OF MEDICAL EXAMINATION (Please type or print)

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.
	1. Head, face, neck and scalp		
	2. Nose		
	3. Sinuses		
	4. Mouth and throat		
	5. Ears, general		
	6. Drums (perforation)		
	7. Eyes, general (Visual acuity under items 27, 28 & 29)		
	8. Ophthalmoscopic		
	9. Pupils (Equality and reaction)		
	10. Ocular motility (Associated parallel movement, nystagmus)		
	11. Lungs and chest (Breasts exam only if clinically indicated or requested)		
	12. Heart (Precordial activity, rhythm, sounds and murmurs)		
	13. Vascular system (Pulse, amplitude and character; arms, legs, others)		
	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 Lymphatics		
	22. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)		
	23. Psychiatric (Appearance, behavior, mood, communication and memory)		
	24. General systemic		

25. BLOOD PRESSURE (Sitting MM Mercury)		26. HEART RATE	27. FIELD OF VISION (Peripheral)	28. DISTANT VISION (Must have BOTH findings)	
Systolic	Diastolic	Resting Pulse	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	Right Eye	UNCORRECTED
			29. Corrective Lens REQUIRED While Driving <small>*If previously "Yes," please include an explanation of the change.</small> NO* _____ YES _____	Left Eye	CORRECTED
				Both Eyes	

30. URINALYSIS (If sugar is positive see #31.)			31. BLOOD SUGAR TEST (Both Fasting & 2 Hour Post Prandial, required only if sugar is found in urine. No S.I. Units)			
SUGAR	ALBUMIN/PROTEIN	BLOOD	FASTING	2-HOUR P.P.	HgA1C	COMMENTS
<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES				

32. OTHER TESTS	33. DISQUALIFYING DEFECTS/LIMITATIONS
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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, must be no older than six months, does not reflect any abnormalities that would preclude the patient from racing. ATTACH all findings, consults, ECG, X-rays, etc. to this report before mailing)

35.a EKG (Date)

MM	DD	YY	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL HEART TROUBLE WITHIN 2 YEARS, MUST SUBMIT RECENT EKG AND CARDIOLOGIST RELEASE.

36. PLEASE CHECK ONE

<input type="checkbox"/> PHYSICALLY ACCEPTABLE
<input type="checkbox"/> FURTHER EVALUATION REQUIRED (Explain)

37. MEDICAL PHYSICIAN/D.O. DECLARATION: I hereby certify that I personally examined the applicant named on 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 (Type or print)
	State License #	Phone: () Fax: ()