

APPLICATION FOR AUSTRALIAN AUTO-SPORT ALLIANCE CLUB RACING LICENCE

NOTE: APPLICANT- PLEASE COMPLETE ALL SECTIONS INCLUDING MEDICAL QUESTIONNAIRE

PLEASE PRINT CLEARLY WHEN COMPLETING THIS FORM

FULL NAME:		ADDRESS IN FULL:	
PHONE:		SUBURB:	
MOBILE:			
BUSINESS:			
OCCUPATION:		POSTCODE:	
COUNTRY OF BIRTH:		DATE OF BIRTH:	AGE:
ARE YOU AN AUSTRALIAN CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO		Tetanus Immunization	Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No
		Date:	If Yes, please list?
Have you previously held a Motor Racing License? <input type="checkbox"/> Yes <input type="checkbox"/> No		Blood Group:	1/
If Yes, last year held?			2/
			3/
Have you ever been diagnosed as having and/or had treatment for:			
	Please Tick		Please Tick
1. A psychiatric or psychological illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Have you taken any medications, including self-medication or alternative therapies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Persistent or severe headache, head injury, epilepsy, seizure or loss of consciousness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Do you have any hearing impairment or loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Heart or lung disease, including infection, blood vessel disease, hypertension, coronary bypass, angioplasty or other surgical procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Do you suffer from any hearing disorder including tinnitus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Cancer, diabetes, kidney, liver, thyroid, gastrointestinal, blood pressure disorders, including any associated surgical procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Is your eyesight normal in both eyes for distance vision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5/ Any other significant illness, injury or surgery not already noted?	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. When did you last have a medical examination?	Date:
Please give full details if you answered YES to any of the above questions:			
Declaration:			
1/ I certify that the statements made regarding my psychological and physical condition and any previous illness are true and accurate.			
2/ I understand that I will not use any drug considered illegal.			
3/ I authorize any hospital or medical practitioner to furnish information relevant to my medical condition to a Medical Assessor in order to determine competition fitness.			
For Female Applicants: I agree to refrain from exercising the rights conferred by the issue of this licence at any time in the last 4 months of pregnancy.			Female Applicant Must Initial
Date:	Signature:	Payment Details	
		Licence Cost \$50.00 valid for 12 months	
Competency Declaration by Club/ Organization or Individual.			
This applicant is recommended by Club/ Organization/ Individual who is personally known to AASA			
Name of Club/ Organization/ Individual:		Signature:	
OFFICE USE ONLY			
Date of Application:	Receipt No:	Receipt Date:	
Licence No:	Renewal Date	Licence Produced:	