Doctors Name / stamp / Date

MEDICAL EXAMINATION FORM:

Please complete sections 1, 2, (2B If applicable) and 3 before attending medical examination

SECTION 1: APPLICANT DETAILS

SURNAME:	**FIRST NAME:**	**HOME:** ( )	**DOB** / /
ADDRESS:		**WORK:** ( )	**AGE:**
CITY:	**POSTCODE:**	**MOB:**	**SEX:** M F

SECTION 2: ANY PREVIOUS MEDICAL HISTORY *Please indicate yes or no as relevant to the following questions.*

1	Nervous disorder (e.g. nerves, anxiety attack)?	Yes		No	12	Injuries related to Motor Sport	Yes	No
2	Headaches?	Yes		No	13	Other injuries?	Yes	No
3	Fits, convulsions, blackouts, fainting, giddiness	Yes		No	14	Other illnesses not mentioned?	Yes	No
4	Asthma, lung disease, respiratory problems?	Yes		No	15	Do you suffer any bleeding disorder?	Yes	No
5	Epilepsy?	Yes		No	16	Do you take any medication on a regular basis?	Yes	No
6	Head injury or concussion?	Yes		No	17	Do you suffer any known allergies?	Yes	No
7	Diabetes?	Yes		No	18	Have you ever been denied life insurance?	Yes	No
8	Heart disease	Yes		No	19	Suffer partial / full single eye blindness	Yes	No
9	Deafness or noises in the ear (e.g. ringing etc)?	Yes		No		**UIM ANTI DOPING FORMS COMPLETED BY APPLICANT (AND DR AS NECESSARY)**		
10	Earache or discharge?	Yes		No	20	UIM Acknowledgement & Agreement Form?	Yes	No
11	Surgical operation?	Yes		No	21	UIM Therapeutic Use Exemption Form (if applcable)	Yes	N/A

IF YOU ANSWERED YES TO ANY QUESTION 1-19 ABOVE PLEASE STATE QUESTION NUMBER & GIVE FULL DETAILS HERE. YOUR DR WILL BE EXPECTED TO COMMENT ON THESE IF NECESSARY. CONTINUE ON SECTION 2B (Page 3) IF INSUFFICIENT SPACE.

Please tick here if you have continued onto section 2B (Page 3): Y

SECTION 3: DECLARATION *(Note: An applicant making a false declaration is liable to refusal or cancellation of license)*

I hereby declare that I do not suffer from any serious illness, disease or restricted vision and that to the best of my belief I have not withheld any relevant information.

Furthermore I declare that should I at anytime while holding a New Zealand Power Boat Federation Inc. competition license, suffer from any illness, disease, or any disability of any kind whether permanent or temporary which is likely to detrimentally affect my control, ability, fitness to compete then I agree to abstain from using the privileges of this license and to notify the New Zealand Power Boat Federation and submit myself for further medical examinations, the result of which will be forwarded to the New Zealand Power Boat Federation.

For female applicants: I agree to abstain from exercising the privileges of this License while in the last six (6) months of pregnancy

PRINT INITIALS AND SURNAME OF APPLICANT: _____

SIGNATURE OF APPLICANT: _____

I consent to the information above, in accordance with the Privacy Act 1993

WITNESS (Print initials and Surname): _____

SIGNATURE OF WITNESS: _____

SECTION 4: MEDICAL PRACTITIONERS DECLARATION: *(Only to be completed if applicant fit to race)*

This is to certify that I have examined the above named person clinically, including eyes, heart, lungs and blood pressure

I have conducted a vision and colours blindness test and he / she is positively able to identify the colours of flags etc used by the NZPBF members, e.g. Red, Green, Black, White, Yellow and Black and White chequered.

This examination does not reveal anything that would make it unsafe for him/her to compete in New Zealand Power Boat Federation sanctioned events:

SIGNATURE OF DOCTOR: _____

DATE OF EXAMINATION: _____

Doctors stamp:

Doctors Name / stamp / Date

MEDICAL EXAMINATION FORM:

Sections 4, 5, 6 (and 5B, 6B if applicable) to be completed and certified by Medical Practitioner only

This applicant is being assessed for medical fitness to partake in high speed motor boat racing.

1 Please attach any specialist reports, or any pathology, or radiology results relevant to this application.
2 The normal answer to each of the questions below is **NO**.
In respect of each **YES** answer, further details / comments should be provided in **Section 6 EXAMINERS COMMENTS**
3 Please check **Section 2 (and 2B, Page 3) ANY PREVIOUS MEDICAL HISTORY** and comment or investigate as necessary.
4 If any significant abnormalities are found, please obtain specialist opinion or pathology as indicated and return with this form.
5 Please check **Section 2 (and 2B, Page 3) ANY PREVIOUS MEDICAL HISTORY** and comment or investigate as necessary.

SECTION 5: MEDICAL PRACTITIONER EXAMINATION: *(please record or tick the yes or no column as appropriate)*

CARDIOVASCULAR SYSTEM		
What is the pulse rate?		
Is the rhythm normal?	Y	N
Blood pressure reading?	/	
Are peripheral pulses abnormal?	Y	N
Any evidence in the history or exam of past or present ischemic heart disease?	Y	N

RESPIRATORY SYSTEM		
Is there any abnormality of the respiratory system on clinical examination?	Y	N

ABDOMEN		
Is there any abnormality of the abdomen on clinical examination?	Y	N

ENT SYSTEM		
Is there any abnormality of the ENT System on clinical examination?	Y	N
Any evidence of past / present vestibular disturbance, include intermittent conditions?	Y	N

LOCOMOTOR SYSTEM		
Has the applicant undergone amputation of any limb or part of a limb, or is there any physical deformity?	Y	N
Does the applicant wear any form of orthopedic device?	Y	N
Has the applicant impaired use or movement of any limb, joint hand, or foot, which might impair or compromise control of a motorboat at speed?	Y	N

CENTRAL NERVOUS SYSTEM		
Is there any abnormality of the cranial nerves, limb tone, power or co-ordination or tendon or plantar response on exam?	Y	N
Is there any sensory impairment	Y	N

VISUAL SYSTEM		
Has the applicant any deformity of the eyes?	Y	N
Is there evidence of horizontal or vertical squint	Y	N
Is there any abnormality or defect in the visual field on confrontment?	Y	N

VISUAL ACUITY (Snellens)	For distance L	For distance R
Unaided	6 /	6 /
Spectacles	6 /	6 /
Contacts	6 /	6 /
Is colour vision abnormal?	Y	N
Was Ishihara method used	Y	N

If **NO** please specify method used:

COMMENTS IN RELATION TO SECTION 2, ANY PREVIOUS MEDICAL HISTORY	
Please tick here if you have continued onto section 5B (Page 3):	Y

SECTION 6: MEDICAL PRACTITIONER EXAMINERS COMMENTS: *(Please continue on Section 6B if necessary)*

Notable problems / conditions

Medications: _____

Disabilities: _____

Allergies:

Examiners comments:

Please tick here if you have continued onto section 6B (Page 3): Y

Are there any unfavorable traits in the applicants personality revealed by history, appearance or behavior?

In your opinion is the applicant fit to participate in motor boat racing **Yes** **No** **Doubtful**

STATEMENT BY EXAMINER:

I have today personally examined this applicant: _____ _____

Signature: Date:

Doctors Name / stamp / Date

Doctors Name / stamp / Date

MEDICAL EXAMINATION FORM:

These sections are supplied for either the applicant or Dr to add further comments as required

Applicant, Have you added any pages, documents, etc? Yes ☐ No ☐ **If yes, how many pages added?** ☐

Doctor, Have you added any pages, documents, etc? Yes ☐ No ☐ **If yes, how many pages added?** ☐

SECTION 2B: ANY PREVIOUS MEDICAL HISTORY CONTINUED: *(If Applicable)*

IF YOU ANSWERED YES TO ANY QUESTION IN SECTION 2 PLEASE STATE QUESTION NUMBER AND GIVE FULL DETAILS HERE. YOUR DR WILL BE EXPECTED TO COMMENT ON THESE IF NECESSARY.

SECTION 5B: MEDICAL PRACTITIONER EXAMINATION COMMENTS CONTINUED: *(If Applicable)*

SECTION 6B: MEDICAL PRACTITIONER EXAMINERS COMMENTS CONTINUED: *(If Applicable)*

OFFICE USE ONLY:

1 Date application received	/ /
2 Any adverse comments?	Yes ☐ No ☐
3 If yes, date passed on?	/ /
License #	Issued: / /
Signed:	Position

Application decision process: *(If required due to medical concerns)*

Dr contacted re concern	/ /	Committee discussed	/ /
Meeting with applicant	/ /	Final decision made	/ /
Application Accepted: ☐	Declined: ☐	Date applicant advised	/ /
Signed		Position in Code	

APPENDIX 2 - Acknowledgment and Agreement

I, as a member of [National Association] : .....

and/or a participant in a [National Association or UIM] authorized or recognized event, hereby acknowledge and agree as follows:

1. I have received and had an opportunity to review the UIM Anti-Doping Rules.
2. I consent and agree to comply with and be bound by all of the provisions of the UIM Anti-Doping Rules, including but not limited to, all amendments to the Anti-Doping Rules and all International Standards incorporated in the Anti-Doping Rules.
3. I acknowledge and agree that [National Associations and UIM] have jurisdiction to impose sanctions as provided in the UIM Anti-Doping Rules.
4. I also acknowledge and agree that any dispute arising out of a decision made pursuant to the UIM Anti-Doping Rules, after exhaustion of the process expressly provided for in the UIM Anti-Doping Rules, may be appealed exclusively as provided in Article 13 of the UIM Anti-Doping Rules to an appellate body for final and binding arbitration, which in the case of International-Level Drivers is the Court of Arbitration for Sport (CAS).
I agree that all decisions of CAS under the rules shall be final and binding and that I will not bring any claim, arbitration, lawsuit or litigation in any other court or tribunal.
5. I have read and understand this Acknowledgement and Agreement.

_____ _____
Date Print Name (Last Name, First Name)

_____ _____

Date of Birth Signature (or, if a minor, signature of legal
(Day/Month/Year) guardian)

Therapeutic Use Exemptions
TUE

Please complete all sections <u>in capital letters or typing</u>

1. Athlete Information

Surname: …… Given names: ……

Female ☐ Male ☐ Date of birth (dd/mm/yy): ……

Address: ……

City: …….. Country:……Postcode:……

Tel.: …… E-mail:……..
(with international code)

Sport:…… Discipline:……

International Sport Organisation: UIM

If athlete with disability, indicate disability:……

2. Medical Information

Diagnosis with sufficient medical information (see note 1):

……

……

……

If a permitted medication can be used to treat the medical condition, provide clinical justification for the requested use of the prohibited medication

……

……

……

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3. Medication details

Prohibited substance(s): ***Generic name***	**Dose**	**Route**	**Frequency**
1.			
2.			
3.			

Intended duration of treatment: *(Please tick appropriate box)*	Once only ☐ Emergency ☐ or duration (weeks/months): ……

Have you submitted any previous TUE application: yes ☐ no ☐

For which substance? .....

To whom? …… When? .....

Decision: Approved ☐ Not approved ☐

4. Medical practitioner's declaration

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medication not on the prohibited list would be unsatisfactory for this condition.

Name: …….

Medical speciality: ……..

Address: …….

Tel.: ……**Fax**: …….

E-mail: …….

Signature of medical practitioner: …… **Date:** ……

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5. Athlete's declaration

I, _____, certify that the information under 1. is accurate and that I am requesting approval to use a Substance or Method from the WADA Prohibited List. I authorise the release of personal medical information to the Anti-Doping Organisation (ADO) as well as to WADA authorised staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorised staff that may have a right to this information under the provisions of the Code.

I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my information; (2) exercise my right of access and correction or (3) revoke the right of these organisations to obtain my health information, I must notify my medical practitioner and my ADO in writing of that fact. I understand and agree that it may be necessary for TUE-related information submitted prior to revoking my consent to be retained for the sole purpose of establishing a possible anti-doping rule violation, where this is required by the Code.

I understand that if I believe that my personal information is not used in conformity with this consent and the International Standard for the Protection of Privacy and Personal Information I can file a complaint to WADA or CAS.

Athlete's signature: …… **Date:** ……

Parent's / Guardian's signature: …… **Date:** ……
(if the athlete is a minor or has a disability preventing him/her to sign this form, a parent or guardian shall sign together with or on behalf of the athlete)

6. Note

Note 1	Diagnosis *Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should include a comprehensive medical history and the results of all relevant examinations, laboratory investigations and imaging studies. Copies of the original reports or letters should be included when possible. Evidence should be as objective as possible in the clinical circumstances, and in the case of non-demonstrable conditions independent supporting medical opinion will assist this application.*

Incomplete applications will be returned and will need to be resubmitted.

Please submit the completed form to the UIM and keep a copy for your records.

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