

**AUSTRALIAN AUTO-SPORT ALLIANCE PTY.LTD
NATIONAL OFF ROAD LICENCE APPLICATION**



SURNAME: _____ CHRISTIAN NAMES: _____

ADDRESS: _____

Postcode: _____

DATE OF BIRTH: _____ AUSTRALIAN CITIZENSHIP YES NO

If No, Nationality on Passport: _____

TELEPHONE: Home: _____ Work: _____

Mobile: _____ Email: _____

Emergency contact: Name: _____ Telephone: _____

Have you competed in a off road motor racing event in the last 12 months? YES NO

If yes, name of last event competed in _____ Date: _____

To obtain your Australian Auto-Sport Alliance Off Road Licence the attached Medical Declaration is to be completed by yourself returned with this application.

Current CAMS Licence Holders please provide proof of CAMS Licence. Please supply details of competition history for the past 12 months.

(attach additional listing if necessary)

For those people who have previously only held a Club level licence must attach a history of at least three (3) events where the Clerk of Course has provided proof of completion of a satisfactory level of competition.

Office Use Only:

Date MER received _____ Licence No: _____ Date mailed: _____

Receipt No. _____ Entered dBase: _____ Renewal Due: _____

LICENCE FEE SCHEDULE

OFF ROAD LICENCE **\$150.00**

Please forward this form along with your payment to: info@aasa.com.au or post to AASA, P O Box 483, Wangaratta. Vic. 3677

PAYMENT DETAILS

Cheque payable to **Australia Auto Sport Alliance Pty. Ltd.** enclosed for \$.....
or charge that amount to my

Visa MC Expiry/.....

Signature



MEDICAL DECLARATION

Information given in this statement will be treated in total confidence although the Chief Medical Officer, upon examining this document, is obliged to advise the Organiser of the Event if, at any time, a participant's medical condition poses an unacceptable risk to that individual or to a co-driver, spectator, race official or any other person attending the Event.

AGE _____ years **CURRENT BODY WEIGHT** _____ kg/lbs **HEIGHT** _____ cms / ins

VISION

While driving, do you wear glasses or contact lenses? Yes / No
 Do you have any problems with colour vision or distance vision? Yes / No

Details: _____

MOBILITY

Do you have any restriction of movement in your limbs? Yes / No
 Do you have any restriction of your ability to enter or leave your vehicle? Yes / No

Details: _____

MEDICAL

Have you ever suffered from any of the following – please circle Yes / No -

Any nervous disorder including nerves, neurasthenia or anxiety state?	Yes / No	Fits, convulsions, turns, blackouts, fainting or giddiness	Yes / No
Headaches	Yes / No	Deafness or noises in the ear	Yes / No
Head injury or concussion	Yes / No	Earache or discharge from the ear	Yes / No
Tuberculosis or lung trouble	Yes / No	Chronic Sinusitis	Yes / No
Rheumatic Fever or Heart Disease	Yes / No	Any surgical operations	Yes / No
Indigestion, gastric or duodenal ulcer	Yes / No	Any injuries related to motorsport	Yes / No
Kidney or bladder trouble	Yes / No	Any other injuries	Yes / No
Diabetes	Yes / No	Any illnesses not already mentioned	Yes / No
Anaemia or other blood disease	Yes / No	Any known allergies	Yes / No

If Yes to any of the above, give full details: _____

MEDICATION

Please list all medication that you may be taking while attending the event – include prescription, over the counter and health shop preparations.

Name of Drug	Strength	Number taken per day

I certify that this is a true statement of my medical condition. I will advise the CMO of any subsequent medical problems that may arise or any medical treatment that may affect my ability to participate in this event.

SIGNED _____ **DATE** _____