APPLICATION FOR DRIVER'S MEDICAL CERTIFICATE

CANADIAN MOTORCYCLE DRAG RACING ASSOCIATION

APPLICANT'S FULL NAME & ADDRESS

Name _____

Address _____

_____

_____

_____

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.

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	☐	☐	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.

APPLICANT'S ACKNOWLEDGEMENT OF RESTRICTED MEDICATIONS: I state and affirm that I have read and understand the following classifications of medications and/or substances that are not allowed for use by any participant: all blood thinners, amphetamines, cocaine, marijuana (cannabis, THC), opiates and phencyclidine (PCP). NOTE: I understand that if there is a possibility that I have taken a medically prescribed Prohibited Substance, it is my responsibility to inform the NHRA National Field Office so that a medical review can be undertaken to determine whether it is acceptable or not. I understand that NHRA's Supervisor of Medical Affairs will make final decisions concerning medical drug clearance issues. I will cooperate in facilitating the medical review including without limitation providing requested medical records and undergoing a physical exam or other testing. I understand that this list of Prohibited Substances in Section 1.7 is for the purposes of this Substance Abuse Policy only and does not limit the substances medically reviewed and allowed or disallowed for purposes of licensure and other participation in NHRA racing, and that further information is in the NHRA Rulebook Section 1.6.1 regarding licensure.

SIGNATURE OF APPLICANT (In ink) _____ DATE _____

AGE	DATE OF BIRTH	HEIGHT	WEIGHT	HAIR	EYES	SEX

APPLICANT'S NAME _____

REPORT OF MEDICAL EXAMINATION *(Please type or print)*

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE COLUMN (Enter NE if not evaluated)
❒	❒	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

NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

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	❒ NORMAL ❒ ABNORMAL		UNCORRECTED	CORRECTED
			29. Corrective Lens REQUIRED While Driving	Right Eye	20/	20/
			❒ NO* ❒ YES	Left Eye	20/	20/
			If previously "Yes," please include an explanation of the change.	Both Eyes	20/	20/

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
❒ NO ❒ YES	❒ NO ❒ YES	❒ NO ❒ YES				

32. OTHER TESTS	33. DISQUALIFYING DEFECTS/LIMITATIONS

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 | EKG must be dated within six months of this exam. | EKG must 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

❒ NORMAL
❒ ABNORMAL
HEART TROUBLE WITHIN 2 YEARS, MUST SUBMIT RECENT EKG AND CARDIOLOGIST RELEASE.

36. PLEASE CHECK ONE

❒ PHYSICALLY ACCEPTABLE
❒ 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 SIGNATURE & STATE LICENSE NUMBER (MD/DO ONLY)	MEDICAL PHYSICIAN (MD/D0 ONLY) NAME, TITLE, ADDRESS & PHONE (TYPE OR PRINT)

AUTHORIZATION FOR RELEASE
OF MEDICAL AND MENTAL HEALTH RECORDS

1. **Persons/Entities Authorized to Release and Disclose Information.** I hereby authorize, empower, request, and direct all healthcare providers, physicians, hospitals, mental health providers, counselors, therapists, clinics, schools, universities, colleges, dispensaries, sanatoriums, any other agencies, motorsports teams and organizations, sanctioning bodies, athletic trainers, facilities, and/or entities that may possess my protected health information ("PHI") (as defined under the Health Insurance Portability and Accountability Act, as amended ("HIPAA") and the regulations thereunder) related to my medical care and treatment ("Records"): (1) to release, disclose, and to make these Records freely available to the persons and entities identified on this authorization as the Authorized Parties; and (2) to discuss the contents of these Records with the Authorized Parties and their representatives.

2. **Persons/Entities Authorized to Receive and Use the Information.** I hereby authorize, empower, and give permission to the following persons and/or entities and their representatives to receive, inspect, copy, obtain copies, examine, and/or use of any and all Records described in this Authorization. These persons and entities will be collectively be referred to as the "Authorized Parties": National Hot Rod Association ("NHRA") and any individuals or entities with which the NHRA has contracted with or employs, including, but not limited to: its medical advisors, designated legal counsel, committees, panels and boards commissioned by NHRA in connection with health and safety initiatives, any outside or third-party physicians, physician groups, hospitals, clinics, laboratories, specialists, pharmacies, and/or healthcare professionals engaged by NHRA in furtherance of my participating in drag racing sanctioned or produced by NHRA, including, but not limited to, providing medical care to me or other services intended to support participant health and safety initiatives, and any present and future electronic medical record vendors and/or prescription networks used by NHRA, and their respective representatives, agents, and/or employees, officers, servants, staff members, and contractors of all the foregoing.

3. **Description of the Information to be Released and Disclosed.** I hereby authorize, empower, direct, and give permission for the following Records to be released and disclosed to the Authorized Parties: my entire health or medical record, including without limitation all written and/or electronic information or data, clinical notes, progress notes, discharge summaries, lab results, pathology reports, operative reports, consultations, physicals, physicians' records, athletic trainers' records, diagnoses, findings, treatments, history and prognoses, test results, laboratory reports, x-rays, MRI, and/or imaging results, outpatient notes, physical therapy records, occupational therapy records, prescriptions, and any and all other information pertaining to my past or present medical condition, diagnosis, treatment, history, and prognosis. This Authorization applies to any and all Records, including, without limitation, medical records which the persons and entities authorized to release and disclose information may have received from another provider, unless access to such PHI has been restricted as permitted under HIPAA or that provider has expressly prohibited re-disclosure. This Authorization expressly includes all Records relating to any mental health treatment, therapy, and/or counseling, but expressly excludes psychotherapy notes.

4. **Purpose of the Disclosure.** This Authorization for Release and Disclosure of Medical and Mental Health Records is for purposes relating to: (a) my actual or potential participation in the drag racing sanctioned or produced by NHRA, including for determining my fitness and ability to participate or be licensed, the provision of trackside emergency response services and care, evaluation of injuries and conditions, which purposes may include review, discussion, processing, and disclosure of my medical records and PHI between and among: (i) any of the Authorized

Parties and (ii) any of my healthcare providers and/or mental health providers; and (b) the administration of NHRA's substance abuse policy.

5. **Expiration.** This Authorization will expire on March 5, 2026.

6. **Photocopy.** A photostatic copy of this Authorization shall be considered as effective and valid as the original.

7. **Re-Disclosure**. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by HIPAA.

8. **Revocation**. I may revoke this authorization by notifying NHRA in writing of my desire to revoke. Revocation should be sent by email to legal@nhra.com and licensing@nhra.com ***or*** by mail delivered to NHRA, Attn: Legal, 140 Via Verde, Suite 100, San Dimas, CA 91773. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

9. **Signature.** By my signature below, I acknowledge that I have read this Authorization, understand my rights as described herein, understand that I am allowing medical and mental healthcare providers to disclose my PHI, and have had any questions answered to my satisfaction. I expressly and voluntarily authorize the release, disclosure, and use of my medical records and/or PHI as described in this Authorization.

_____
Signature

_____
Print Name

_____
Date