



# MEDICAL SELF-DECLARATION

Applicant information and completion instructions

## MEDICAL DECLARATION REQUIREMENTS

**Limited class riders applying for an Open Licence:** complete a medical self-declaration annually.

**All other classes:** complete a medical self-declaration every two years.

**Any “Yes” answer:** a supporting doctor’s certificate is required if any condition in Section 2 is answered “Yes”.

## HOW TO COMPLETE AND RETURN THIS FORM

1. Complete Sections 1, 2 and 3 clearly.
2. If you answer “Yes” to any condition, take this form to a doctor. The doctor must complete Sections 4 and 5.
3. Where a doctor’s assessment is required, the doctor retains Sections 1-4. Return Section 5 to the NZJSBA Licence Officer.
4. If no doctor’s assessment is required, submit Sections 1-3 with your licence application.

## SECTION 1 | APPLICANT DETAILS

|                               |  |
|-------------------------------|--|
| Surname                       |  |
| Given names                   |  |
| Date of birth                 |  |
| Residential address           |  |
| Region / postcode             |  |
| Postal address (if different) |  |
| Postal region / postcode      |  |
| Mobile phone                  |  |
| Other contact phone           |  |
| Email                         |  |
| Occupation                    |  |

# HEALTH DECLARATION

Complete every question. Tick one answer in each row.

## SECTION 2 | TO BE COMPLETED BY APPLICANT

| QUESTION                                                                               | YES                      | NO                       |
|----------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <b>A</b> Do you currently have any disease or disability?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>B</b> Have you ever suffered anxiety, depression or any nervous or mental disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>C</b> Have you ever had recurrent or severe headaches?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>D</b> Have you ever had epilepsy, fits, turns or blackouts?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>E</b> Have you ever had fainting, giddiness or dizziness?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>F</b> Have you ever had a head injury or concussion?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>G</b> Have you ever had tuberculosis, bronchitis, asthma or pneumonia?              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>H</b> Have you ever had rheumatic fever or heart disease?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I</b> Have you ever had indigestion, gastric or duodenal ulcer?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>J</b> Have you ever had kidney or bladder trouble?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>K</b> Have you ever had diabetes?                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>L</b> Have you ever had anaemia or another blood disorder?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>M</b> Have you ever had jaundice, hepatitis or glandular fever?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>N</b> Have you ever had noises in the ear, earache or discharge?                    | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>O</b> Have you ever had chronic sinus trouble?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>P</b> Have you ever had a surgical operation?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Q</b> Have you ever had a fracture or broken bone?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>R</b> Have you ever had any illness or injury not mentioned above?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>S</b> Do you wear glasses or contact lenses?                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>T</b> Do you take tablets, injections or any other medication?                      | <input type="checkbox"/> | <input type="checkbox"/> |

For each "Yes", attach details: include the question letter, condition, dates and current treatment or medication. A supporting doctor's certificate is required.

## SECTION 3 | APPLICANT DECLARATION

I, \_\_\_\_\_, declare that I have carefully considered my answers and, to the best of my knowledge, they are complete and correct. I have not withheld information or made a misleading statement.

If I sustain an accident or injury, or any answer no longer applies during the currency of a licence issued based on this declaration or examination, I agree to immediately surrender that licence to NZJSBA and submit to a further medical examination.

I authorise the Medical Assessor or their representative to obtain relevant clinical records, X-rays and pathology reports from hospitals or medical practitioners I have attended.

If a female applicant, I agree to abstain from exercising the privileges of this licence in the last four (4) months of pregnancy.

Applicant signature

Date

Witness / Medical Examiner name and signature

# MEDICAL EXAMINATION

Confidential clinical report | To be retained by the Medical Examiner

## SECTION 4 | TO BE COMPLETED BY MEDICAL EXAMINER

|                                 |  |
|---------------------------------|--|
| Applicant name                  |  |
| Age / height (cm) / weight (kg) |  |
| Pulse rate / blood pressure     |  |

|                                     | Normal                   | Abnormal                 |                               | Normal                   | Abnormal                 |
|-------------------------------------|--------------------------|--------------------------|-------------------------------|--------------------------|--------------------------|
| <b>CARDIOVASCULAR SYSTEM</b>        |                          |                          | <b>CENTRAL NERVOUS SYSTEM</b> |                          |                          |
| Heart size                          | <input type="checkbox"/> | <input type="checkbox"/> | Intellect                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart sounds                        | <input type="checkbox"/> | <input type="checkbox"/> | Deep reflexes                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Murmurs                             | <input type="checkbox"/> | <input type="checkbox"/> | Coordination                  | <input type="checkbox"/> | <input type="checkbox"/> |
| ECG (if required)                   | <input type="checkbox"/> | <input type="checkbox"/> | <b>LIMBS</b>                  |                          |                          |
| <b>RESPIRATORY SYSTEM</b>           |                          |                          | Deformity                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Air entry                           | <input type="checkbox"/> | <input type="checkbox"/> | Range of joint movement       | <input type="checkbox"/> | <input type="checkbox"/> |
| Breath sounds                       | <input type="checkbox"/> | <input type="checkbox"/> | <b>URINE</b>                  |                          |                          |
| Accompaniments                      | <input type="checkbox"/> | <input type="checkbox"/> | Protein                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>ABDOMEN</b>                      |                          |                          | Glucose                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Viscera                             | <input type="checkbox"/> | <input type="checkbox"/> | <b>VISUAL SYSTEM</b>          |                          |                          |
| Hernia orifices                     | <input type="checkbox"/> | <input type="checkbox"/> | Eyes - any abnormality        | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>ENT &amp; VESTIBULAR SYSTEMS</b> |                          |                          | General inspection            | <input type="checkbox"/> | <input type="checkbox"/> |
| Tympana                             | <input type="checkbox"/> | <input type="checkbox"/> | Eye movements / cover test    | <input type="checkbox"/> | <input type="checkbox"/> |
| Nystagmus                           | <input type="checkbox"/> | <input type="checkbox"/> | Fields / confrontation test   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sharpened Romberg                   | <input type="checkbox"/> | <input type="checkbox"/> |                               |                          |                          |

## VISUAL ACUITY

|                 |                |               |
|-----------------|----------------|---------------|
| Natural sight   | Right 6/ _____ | Left 6/ _____ |
| With correction | Right 6/ _____ | Left 6/ _____ |

### Examiner comments - history

### Examiner comments - examination



# DOCTOR'S CERTIFICATE

Return this page to the NZJSBA Licence Officer when a doctor's assessment is required.

## SECTION 5 | MEDICAL EXAMINATION RECORD

Please print clearly. The Medical Examiner must complete, sign and date this certificate and add their practice stamp.

### APPLICANT DETAILS

|                     |  |
|---------------------|--|
| Surname             |  |
| Given names         |  |
| Date of birth       |  |
| Residential address |  |

### STATEMENT BY MEDICAL EXAMINER

Today I have examined:

I find this applicant **FIT / UNFIT** (please circle) to participate in personal watercraft (jet sport) racing.

Medical Examiner name

Medical Examiner signature

Examination date

Medical practice stamp (over or beside the signature)

### NZJSBA OFFICE USE ONLY

|                              |  |
|------------------------------|--|
| Date received                |  |
| Licence number / race number |  |
| Next medical declaration due |  |