Page	1	of	٦
гауе		UI	J



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:	номе: ()	DOB / /
ADDRESS:		work: ()	AGE:
	POSTCODE:	МОВ:	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	ill'	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):

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: Doctors stamp:

SIGNATURE OF DOCTOR:

DATE OF EXAMINATION:

Page 2 of 3

 NZ
 Fe d e r a t i o n lnc.

 Fohrer Boat Association of New Zealand Inc.
 NZ JET BOAT Kasociation of New Zealand Inc.

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	LOCOMOTOR SYSTEM	VISUAL SYSTEM
What is the pulse rate?	Has the applicant undergone Y N	Has the applicant any Y N
Is the rhythm normal? Y N	amputation of any limb or part	deformity of the eyes?
Blood pressure reading?	of a limb, or is there any	Is there evidence of Y N
Are peripheral pulses abnormal? Y	physical deformity?	horizontal or vertical squint
Any evidence in the history	Does the applicant wear any Y N	Is there any abnormality or Y N
or exam of past or present	form of orthopedic device?	defect in the visual field on
ischemic heart disease?	Has the applicant impaired use Y N	confrontment?
	or movement of any limb, joint	
RESPIRATORY SYSTEM	hand, or foot, which might	VISUAL ACUITY For distance
Is there any abnormality of the Y N	impair or compromise control	(Snellens) L R
respiratory system on clinical	of a motorboat at speed?	Unaided 6 / 6 /
examination?		Spectacles 6 / 6 /
	CENTRAL NERVOUS SYSTEM	Contacts 6 / 6 /
ABDOMEN	Is there any abnormality of the Y N	Is colour vision abnormal? Y N
Is there any abnormality of the Y N	cranial nerves, limb tone, power	Was Ishihara method used Y N
abdomen on clinical	or co-ordination or tendon or	If NO please specify method used:
examination?	plantar response on exam?	41 1
	Is there any sensory impairment Y N	
ENT SYSTEM		
Is there any abnormality of the Y N	COMMENTS IN RELATION TO SECTION 2, AN	NY PREVIOUS MEDICAL HISTORY
ENT System on clinical		
examination?		
Any evidence of past / present Y N		
vestibular disturbance, include		
intermittent conditions?	Please tick here if you ha	ave continued onto section 5B (Page 3): Y
SECTION 6: MEDICAL PRACTITIONER	EXAMINERS COMMENTS: (Please contin	nue on Section 6B if necessary)
Notable problems / conditions		
Medications:		
Disabilities:		
Allergies:		
Examiners comments:		
	D	
Are there only unforce the troits in the annih		ave continued onto section 6B (Page 3): Y
Are mere any unavorable traits in the applic	cants personality revealed by history, appearar	
In your opinion is the applicant fit to particip	bate in motor boat racing Yes No D	Doubtful
STATEMENT BY EXAMINER:		
I have today personally examined this ap	plicant:	
	Signature: Date	e: Doctors Name / stamp / Date
		<u> </u>

N ZPOWERBOAT	Page 3 of 3
POWER BOAT ASSOCIATION ASSOCIATION ASSOCIATION OF New Zealand Inc.	Doctors Name / stamp / Date
MEDICAL EXAMINATION FO	RM:
These sections are supplied for either the applicant or Dr to add	
Applicant, Have you added any pages, documents, etc? Yes No If y	es, how many pages added?
Doctor, Have you added any pages, documents, etc? Yes No If y	es, 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 NUMB YOUR DR WILL BE EXPECTED TO COMMENT ON THESE IF NECESSARY.	ER AND GIVE FULL DETAILS HERE.
	(If Applicable)
SECTION 5B: MEDICAL PRACTITIONER EXAMINATION COMMENTS CONTINUED	
SECTION 6B: MEDICAL PRACTITIONER EXAMINERS COMMENTS CONTINUED: ((If Applicable)

Г

OFFICE USE ONLY:

1 Date application received		/] ▶	Application decision	on proce	ess	s: <i>(If i</i>	required due to medical	conce	rns)
2 Any adverse comments?	Yes	No		Dr contacted re concern	/		/	Committee discussed	/	1
3 If yes, date passed on?	1	1		Meeting with applicant	1		/	Final decision made	1	1
License # Issued:	/	1		Application Accepted:	Decline	ed:		Date applicant advised	1	1
Signed: Position	1			Signed			Posi	tion 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 in capital letters or typing

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 disabilit	y:

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

STRICTLY CONFIDENTIAL

3. Medication details

Prohibited substance(s): <u>Generic name</u>	Dose	Route	Frequency
1.			
2.			
3.			

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

Have you submitted any previous TUE application:			yes 🗆	no 🗆
For which substance?				
To whom?			/hen?	
Decision:	Approved	Not approve	d 🗆	

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.:F	ax:
E-mail:	
Signature of medical practitioner:	Date:

STRICTLY CONFIDENTIAL

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: (if the athlete is a minor or has a disability preventing him/her to sign 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.

STRICTLY CONFIDENTIAL