

**Important** If significant abnormalities are found, please obtain specialist opinion or pathology as indicated and return with this form. If doubtful, refer to CAMS Member Hotline – 1300 883 959.

**Notes:**

1. Photo ID required.
2. Please attach any Specialists' reports or any pathology or radiology results relevant to this application.
3. If the applicant wears contact lenses, please attach to this report a certificate from the Ophthalmic Practitioner who fitted them, stating their (i) stability, (ii) duration of daily use and (iii) condition.
4. BMI (i) The Body Mass Index is weight (in kilograms) divided by the square of the height (in metres).  
 (ii) 20-25 Acceptable – normal range  
 25-30 Health risk area  
 30-35 Obese  
 35-40 Morbidly obese
5. References to Cardiovascular or CV score allude to the Framingham Study.
6. The 'normal' answer to each question below is 'NO'. In respect of each 'YES' response, further details should be provided in Examiner's Comments.

Member's name: \_\_\_\_\_ Member (licence) no: \_\_\_\_\_ Licence level: \_\_\_\_\_

What is the applicant's: Height (in cm) \_\_\_\_\_ Weight (in kg) \_\_\_\_\_ Body Mass Index \_\_\_\_\_ CV Score \_\_\_\_\_

Reference to CV Score chart also required for all applicants.

**Cardiovascular System**

What is the pulse rate? (MAX 100) \_\_\_\_\_

Is the rhythm abnormal?  Yes  No

What is the blood pressure? (MAX 150/90) \_\_\_\_\_ / \_\_\_\_\_

Are the peripheral pulses abnormal?  Yes  No

Is there any evidence in the history or examination of past or present ischaemic heart disease?  Yes  No

Fasting LIPIDS LDL \_\_\_\_\_  
 HDL \_\_\_\_\_

Fasting GLUCOSE \_\_\_\_\_

**Respiratory System**

Is there any abnormality of the respiratory system on examination?  Yes  No

Is the applicant a smoker?  Yes  No

**Abdomen**

Is there any abnormality of the abdomen on clinical examination?  Yes  No

**Urinary Examination**

Does the applicant's urine contain Protein  Yes  No

Glucose  Yes  No

Other abnormality?  Yes  No

**Locomotor System**

1. Physical deformity, amputation or use of any orthopaedic appliance?  Yes  No

2. Is there any impaired functional use, either from 1 (above) or otherwise?  Yes  No

Has the applicant impaired use or movement of any limb, joint, hand or foot which might impair or compromise control of a motor vehicle?  Yes  No

**Central Nervous System**

Is there abnormality of the cranial nerves, limb tone, power or co-ordination or tendon or plantar response on examination?  Yes  No

Is there any sensory impairment?  Yes  No

**ENT System**

Is there any evidence of past or present vestibular disturbance, including intermittent conditions?  Yes  No

Is there any abnormality of the ENT system on clinical examination?  Yes  No

**Visual System**

Has the applicant any evident abnormality of the eyes?  Yes  No

Are contact lenses worn?  
 (Certificate of Ophthalmic Prac. required if YES)

Has the applicant undergone refractive surgery?  
 (Certificate of Ophthalmic Practitioner required if YES)

**Visual Acuity**

Test each eye separately with letter chart at 6m

Record in metric Snellen notation: eg, 6/9

Record number of errors made in smallest line read: eg, 6/9 -3 RE LE

Unaided (without contact lenses or spectacles) 6/ \_\_\_\_\_ 6/ \_\_\_\_\_

With spectacles or contact lenses 6/ \_\_\_\_\_ 6/ \_\_\_\_\_

**Visual fields**

Do a confrontation test for each eye separately.

Is there any ocular or general medical history that suggests the possibility of visual field loss?  Yes  No

Does the confrontation test suggest a loss of visual fields in either eye?  Yes  No

**Colour vision**

Test with Ishihara for first licence only.

More than three (3) errors is a FAIL indicating abnormal colour vision.

Ishihara test failed?  Yes  No

If YES, the applicant will most likely need to be referred for a full eyesight examination by an optometrist or an ophthalmologist or

when visual acuity (with glasses if any or unaided if no glasses) is:

– less than a full 6/7.5 in either eye (International Licence)

– less than 6/9 -2 in the better eye or less than 6/18 -2

in the other eye (National Licence)

The applicant should contact CAMS to obtain a copy of the Vision Report Form to be completed by the optometrist or ophthalmologist they consult. When completed, the form should be returned to CAMS and included with the Medical Examination Record. CAMS will take into account the optometrist/ophthalmologist report when determining the applicant's fitness to participate in motor sport.

**ECG**

A **resting ECG** is required with **all** Medical Examinations.  
For International Licence applicants, a **Stress ECG** is required every **second year after age 45**.

**Stress ECG**

ECG Results: \_\_\_\_\_ / \_\_\_\_\_

Other comments:

ECG abnormal?  **Yes**  **No**

If abnormal, date completed: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Examiner's Comments**

1 On history:

2 Are there any unfavourable traits in applicant's personality, revealed by history, appearance or behaviour?

3 Has the applicant been prescribed drugs which are in contravention of the CAMS Anti-Doping policy, or inhaled asthma medications?  
If so, please advise drug, dosage and reason:

4 In your opinion, is the applicant fit to participate in motor sport?  **YES**  **NO**  **FURTHER ASSESSMENT**

**Statement by Registered General Practitioner**

The applicant was examined on: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Examiner's signature

Applicant's photo ID sighted?  **YES**  **NO**

SIGN HERE

Are you the applicant's normal GP?  **YES**  **NO**

Name of medical examiner: \_\_\_\_\_

Address of medical examiner: \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_



**This medical is only valid for 3 months from the date of examiners signature**

Please return to: MEMBER SERVICES, PO BOX 427, CAULFIELD EAST, VIC 3145 or email to: memberservices@cams.com.au

**MEMBER SERVICES AND STATE MEDICAL ASSESSORS USE ONLY**

CAMS MEMBER NO.

NEXT EXAM DUE

INT

Medical every year

NAT

Medical every two years

UNFIT

MEDICAL DETAILS TO BE ENTERED ON LICENCE:

ASSESSOR'S SIGNATURE

VISUAL CORRECTION REQUIRED?  **YES**  **NO**

SIGN HERE

OTHER (PLEASE SPECIFY):

DATE \_\_\_\_\_ - \_\_\_\_\_