VINTAGE SPORTS CAR DRIVERS ASSOCIATION, Ltd.
9780 Rolling Hills Drive ● Alto, MI 49302
Phone: 616-891-0091 ● Fax: 616-891-5616
E-mail: vscda@hughes.net
Website: www.vscda.org
Office Hours: Monday thru Friday, 10 AM to 6 PM EST

Dear Doctor,

You are being asked to examine this individual who is applying for competition racing privileges with Vintage Sports Car Drivers Association, Ltd, (VSCDA). This form concentrates on the organ system and disease processes that may jeopardize the Applicant or others attending a competition race event.

The functional requirements of the Applicant to drive in a competition automobile are:

1. Brain: the ability for rapid mental activity and problem solving.
2. Limbs: the ability to rapidly operate acceleration, braking and steering mechanisms/systems (mechanical assistance allowed).
3. Vision: distant vision correctable to 20/30 each eye, normal depth perception, peripheral vision to 70 degrees in the horizontal median for each eye and the ability to distinguish basic colors.
4. Minimal chance of sudden incapacitation from any disease process.

The environment in which the Applicant may operate a competition automobile is:

1. Temperature extremes from 0 to 120 degrees, external to the vehicle. Internal vehicle temperature may be much hotter.
2. Smoke, fumes, vapor and dust.
3. Noise and vibration.
4. Potential for the presence of fire.

Applicants are required to submit a current physical examination every two (2) years.

Thank you for your cooperation!

The VSCDA Board of Directors

Attachment

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PHYSICIAN'S EXAMINATION

To be completed by Physician and submitted with Applicant's Medical History

Applicant's Name ________ Age ________ Gender ________

Height ________ Weight ________ Hair Color ________ Eye Color ________

Blood Type ________ Blood Pressure ________ Pulse ________ Respirations ________

Date of Last Tetanus ________

At a minimum, please examine for abnormalities in Neurological system, Vision, Cardiac system and Metabolic system.

Neurological:

- □ Normal
- □ Abnormal, because ________

Vision: Minimum of 20/30 corrected vision in each eye, depth perception, peripheral vision to 70 degrees in the horizontal median for each eye and ability to distinguish colors.

- □ Normal
- □ Abnormal, because ________

Cardiac:

- □ Normal
- □ Abnormal, because ________

Metabolic:

- □ Normal
- □ Abnormal, because ________

Comments or concerns that the VSCDA Board of Directors should be aware of ________

____

I certify that based on the instructions given to me, this limited examination and review of the Applicant's Medical History, I am not aware of any medical reason that should prevent this Applicant from driving a high speed competition automobile.

Physician's Signature ________ Date ________

Physician's Name ________ Phone ________

Address ________ City/Province ________ State/Country ________ Zip ________

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APPLICANT'S MEDICAL HISTORY

To be completed by Applicant and submitted with Physician's Examination

Applicant – In order for you to obtain driving privileges with VSCDA you must complete this page, legibly and in its entirety. You must also submit the Letter and Physician's Examination form to your Doctor for completion. Failure to provide the required information will delay the processing of your driving privileges.

Name ____________ Date of Birth ________ Gender ________ Marital Status ________

Address ____________ City/Province ________ State/Country ________ Zip ________

Home Phone ________ Work Phone ________ E-mail ____________

Occupation ____________ Years as a Racer ____________

Your Personal Physician ____________ Phone ____________

Address ____________ City/Province ________ State/Country ________ Zip ________

Examining Physician ____________ Phone ____________

Address ____________ City/Province ________ State/Country ________ Zip ________

Have you ever had, currently have or been treated for any of the following:
(Yes responses should be explained on a separate sheet and attached)

Conditions	Yes	No	Conditions	Yes	No
Psychiatric/Mental Health problems	___	___	Amputations/Physical limitations	___	___
Headaches frequent or severe	___	___	Anemia or other blood diseases,		
Dizziness or Fainting spells	___	___	incl. abnormal bleeding	___	___
Unconsciousness for any reason	___	___	Asthma	___	___
Epilepsy or Seizures	___	___	Diabetes	___	___
Eye problems (except glasses)	___	___	Hay Fever	___	___
Heart problems:			Illness(es) not mentioned above	___	___
Abnormal Cardiac Rhythms	___	___	Admission to a hospital in the		
Angina or Coronary Artery Disease	___	___	past 12 months	___	___
Left Bundle Brach Block	___	___	Operation(s) involving Brain, Eyes,		
Valve Disease	___	___	Heart, Blood Vessels, Nerves		
High Blood Pressure	___	___	or Bones	___	___
Any Drug, Narcotic or Alcohol use	___	___	Any previous licensure denial(s) due		
Allergy(s) to medications	___	___	to a medical reason(s)	___	___

Date of last Tetanus ____________ Blood Type ____________

Medications Used (incl. eye drops) ____________

Comments ____________

I certify that these statements are true and accurate. I also give permission to any physician, hospital or institution to furnish any information to the VSCDA Board of Directors upon their request.

Applicant's Signature ____________________ Date ____________