



2023 MEDICAL DECLARATION

RETURN FORM TO: bevan@torqueqld.com.au

SURNAME:			
GIVEN NAMES:			
RESIDENTIAL ADDRESS:			
SUBURB:		POSTCODE:	
POSTAL ADDRESS:			
SUBURB:		POSTCODE:	
PHONE:		EMAIL:	
OCCUPATION:			

STATEMENT BY APPLICANT	YES	NO
Do you, at present, have any disease or disability?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever suffered from:		
a) Anxiety State. Depression or any nervous or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b) Headaches - recurrent or severe?	<input type="checkbox"/>	<input type="checkbox"/>
c) Epilepsy, fits, turns or blackouts?	<input type="checkbox"/>	<input type="checkbox"/>
d) Fainting, giddiness, or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
e) Head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
f) TB, Bronchitis, Asthma or Pneumonia?	<input type="checkbox"/>	<input type="checkbox"/>
g) Rheumatic Fever or heart disease?	<input type="checkbox"/>	<input type="checkbox"/>
h) Indigestion, gastric or duodenal ulcer?	<input type="checkbox"/>	<input type="checkbox"/>
i) Kidney or bladder trouble?	<input type="checkbox"/>	<input type="checkbox"/>
j) Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
k) Anemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>
l) Jaundice, hepatitis, or glandular fever?	<input type="checkbox"/>	<input type="checkbox"/>
m) Noises in ear, earache, or discharge?	<input type="checkbox"/>	<input type="checkbox"/>
n) Chronic sinus trouble?	<input type="checkbox"/>	<input type="checkbox"/>
o) Any surgical operation?	<input type="checkbox"/>	<input type="checkbox"/>



p) Any fracture or broken bones?	<input type="checkbox"/>	<input type="checkbox"/>
q) Any illness or injury not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
r) Wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
s) Take any tablets, injections, or other form of medication?	<input type="checkbox"/>	<input type="checkbox"/>

For each 'Yes' answer, please provide full details (including dates where applicable) in space below:

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Note: if there is not enough space here, please attach an additional page with the details. Declaration to be completed by Applicant

I, _____ hereby declare that I have carefully considered my answers to the questions above, and that to the best of my knowledge that they are complete and correct and I have not withheld any information or made any misleading statement. Furthermore, I declare that, should I sustain any accident or injury, or should any of the above answers not continue to apply throughout the currency of any licence issued to me on the basis of this medical examination, I agree to immediately surrender such licence to Mackay Power Boat Club and agree to submit myself for a further medical examination. If a female applicant, I agree to abstain from exercising the privileges of this licence in the last four (4) months of pregnancy.

SIGNATURE:		DATE:	
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