VINTAGE SPORTS CAR DRIVERS ASSOCIATION, Ltd.
1600 W. Market Street Logansport, IN 46947
616.916.2650 FAX: 574.753.4115 vscda@vscda.org

Dear Doctor,

You are being asked to examine this individual who is applying for competition racing privileges with the 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 and to rapidly exit the car without assistance.
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:
   a) Temperature extremes from 0 to at least 120 degrees.
   b) Smoke, fumes, vapor, and dust.
   c) Noise and vibration, deceleration ad cornering forces.
   d) 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

Member number _____

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PHYSICIAN'S EXAMINATION
(please print)

Applicant's Name _____ Date of Birth_____

Address_____Phone (____) _____

E-mail address _____Date of last Tetanus _____

At a minimum, please examine for abnormalities in Neurological system, Vision, Cardiac and Vascular System, Respiratory System, and Endocrine system.

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

_____

_____

_____

I certify that based on the instructions given to me, my personal 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 (please print) Phone

_____
Address City/Province State/Country Zip

I understand that I will notify the VSCDA of any change in my physical status occurring before my next exam. Failure to do so may result in loss of driving privileges. I also give permission to any physician, hospital or institution to furnish any information to the VSCDA Board of Directors upon their request.

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Applicants Signature Date (Revised 2017)