

Please have your physician (MD, DO, PA-C, or NP) complete the following form, complete all signatures, and send it to:

IMG Membership Applications - 119 Walter St, South Plainfield, NJ 07080 or email it to membership@imgracing.com

Memorandum to the Examining Physician

The three pages of this form are collectively referred to as the "Physical Examination." You are being asked to examine this applicant for the purpose of obtaining an automobile racing license. This form concentrates on the organ system and disease processes that may jeopardize the applicant or others while attending a competitive racing event. If you deem that the applicant may be in questionable condition, the matter may be turned over to the IMG Medical Director for review.

A. The functional suggested requirements of a driver in a competition automobile are:

1. Ability to rapidly operate acceleration, braking, and steering mechanisms/systems
2. Vision: distant vision correctable to 20/40 each eye, ability to distinguish basic colors, and peripheral vision to 70 degrees in the horizontal median for each eye
3. Should have minimal chance of sudden incapacitation from any disease process
4. Ability for rapid mental activity, problem solving, and decision-making

B. The environment this applicant may operate in is:

1. Temperature extremes from 0 degrees (F) to 120 degrees (F) for long periods of time
2. Smoke, fumes, vapor, caustic chemicals, and dust
3. Loud noise and vibration
4. Increased potential for exposure to fire

Requirement of All Applicants*: All applicants must submit a completed MEDICAL HISTORY (page 2) and PHYSICIAN'S EXAM (page 3). Similar forms from other recognized organization and agencies may be acceptable, however the applicant will be held accountable to the rules, laws, and other parameters, as set forth by the issuing organization or agency.

Renewals:

- Applicants that are less than 40 years old must renew their Physical Examination every five years
- Applicants that are at least 40 years old must renew their Physical Examination every three years
- Applicants that are at least 50 years old must renew their Physical Examination every two years
- Applicants that are at least 60 years old must renew their Physical every 12 months

Note to the examining physician: Please note the "Renewals" section of this document (above). Consideration should be given to the length of time between examinations, unless otherwise specified with highlighted notation in the comment section found on the PHYSICIAN'S EXAMINATION page of this document.

***Exceptions:** Medical Waivers may be granted in certain circumstances with the approval of the proper authorities, as listed on the Application for a Medical Waiver form. Drivers that have been granted a Medical Waiver may be subject to special requirements as the IMG review board stipulates.

Medical History

(To be completed by applicant)

Name _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Occupation _____

Phone (Home) _____ (Work) _____ (Cell) _____

Personal Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Examining Physician _____ Phone _____

Please indicate if you have ever had, or have now, any of the following:

Conditions	Yes	No
Frequent or severe headaches		
Unconsciousness for any reason		
Dizziness or Fainting Spells		
Epilepsy or seizures		
Coronary artery disease or angina		
Heart valve disease		
Left Brundle Branch Block (heart)		
Abnromal cardiac rhythms		
High Blood Pressure		
Drug, narcotic, or alcohol problems		
Psychiatric / mental health problems		
Operation(s) on brain		
Operation(s) on heart		
Operation(s) on eyes, nerves, blood vessels, or bone		
Previous IMG medical waiver(s) (please attach)		

Condition	Yes	No
Hay fever		
Eye problems (except glasses)		
Asthma		
Diabetes		
Anemia or abnormal bleeding		
Other blood diseases		
Admission to hospital in last 12 months		
Allergy to medications List:		
Amputations / physical disability		
Previous denial(s) from any sanctioning body due to medical reasons		
Illnesses not listed above:		

Date of last Tetanus _____ Blood Type _____ Blood thinner medication (circle): YES or NO

Comments and details of any condition noted above: _____

Medications used (including eye drops): _____

I certify that the above is true and correct. I also give permission for IMG administration to access and/or exchange information with health care providers as well as the medical administration of other sanctioning bodies.

Applicant Signature

Date

Physician's Examination

Applicant Name _____ Date _____
Age _____ Gender _____ Height _____ Weight _____ Hair Color _____
Eye Color _____ Respirations _____ Pulse _____ Blood Pressure _____

Note: Applicants with the following conditions must be referred to the IMG competition board for review:

- Less than 20/40 corrected vision in the better eye
- Alcohol or drug addiction
- All gross deformities subject to listing
- Blood pressure: Diastolic over 90 or systolic over 160
- History of Syncope
- Loss of extremity or eye
- Diabetes
- Loss of color vision
- Psychological problems
- Epilepsy
- Implanted Defibrillator
- Coronary Artery Disease / Stent / CABG / or MI
- History of Cardiac Arrhythmias

Vision - Abnormalities require an attached ophthalmological consult

Vision (corrected) OD _____ OS _____ OU _____

Color Vision _____ Test _____

Peripheral Vision (degrees from midline) _____ OD _____ OS _____ Test _____

Neurological – Abnormalities require an attached neurological consult

Reflexes: ___ Normal ___ Abnormal

Cerebellar: ___ Normal ___ Abnormal

Other test performed: _____

Cardiac – Abnormalities require an attached cardiologic consult

At the age of 40, a baseline EKG should be performed. Further EKGs are required only if the applicant is a smoker, has a cardiac history, a strong family history of cardiac disease, history of diabetes, or has hypertension (systolic > 140 or diastolic > 90).

Cardiac Exam: ___ Normal ___ Abnormal ___ N/A

Please attach a copy of any EKG results

Metabolic – Please attach an HgbA1C and Endocrinologic consult for any history of diabetes

History of diabetes: ___ Yes ___ No

HgbA1C (less than 10) _____

Comments or concerns regarding past or present health or medications that we should be aware of:

On the basis of this limited examination and review of the applicant's medical history, please complete the following:

_____ PASS – Applicant is fit for motor racing	_____ FAIL or NEEDS REVIEW
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Physician's Signature _____

Physician's Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____