GAMBLING REGULATORY AUTHORITY

# RIDER'S MEDICAL DECLARATION FORM

## Part A - Rider's Licence Personal Information

This section is to be completed by the applicant.

Type of Licence: *(Please tick as appropriate)*

Jockey ☐ Apprentice Jockey ☐ Trackwork Rider ☐

### Personal Information

| | | | |
|---|---|---|---|
| Last Name: | | D.O.B: | |
| First Name(s): | | Height: | |
| Nic/Passport No.: | | | |
| Residential Address: | | | |
| Contact Telephone (Home): | | (Mobile): | |
| Email Address: | | | |

### Emergency Contacts (in an emergency, the persons to be contacted on your behalf

Contact 1:

| | | | | | | |
|---|---|---|---|---|---|---|
| Name: | | | | Relationship: | | |
| Address: | | | | | | |
| Telephone: | Home: | | Work: | | Mobile: | |

Contact 2:

| | | | | | | |
|---|---|---|---|---|---|---|
| Name: | | | | Relationship: | | |
| Address: | | | | | | |
| Telephone: | Home: | | Work: | | Mobile: | |

### Licence Refusal or Deferments

| Has the applicant ever had a licence to ride refused or deferred on medical grounds? | Yes | No |
|---|---|---|

| Date of refusal or deferment | Date of Reinstatement | Reason |
|---|---|---|
| | | |
| | | |



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**Part B - Rider's Licence Medical Information**

This section is to be completed by the rider applicant.

Have you experienced or do you suffer from any of the following conditions below *(please tick)*?

| Ref. | Condition / Injuries / Illnesses | Yes | No |
|---|---|---|---|
| 1 | Nervous disorders including, nerves, depression, nervous breakdown, mental or emotional instability, anxiety or attempted suicide. | | |
| 2 | Headaches or Migraines | | |
| 3 | Fits, Convulsions, turns, blackouts, giddiness or epilepsy | | |
| 4 | Lung or chest infections, pneumonia, bronchitis, asthma or tuberculosis | | |
| 5 | Heart disease, high or low blood pressure, rheumatic fever or angina pectoris | | |
| 6 | Indigestion, pain after eating, gastric or duodenal ulcers, hiatus hernia, gall bladder disease, recurrent diarrhoea or appendicitis | | |
| 7 | Kidney or bladder problems, cystitis (inflammation of the bladder) or stones | | |
| 8 | Diabetes, goitre, thyroid disease or any disease of the lymphatic glands | | |
| 9 | Anaemia or blood disease | | |
| 10 | Perforated ear drums, deafness, tinnitus (noises in the ears) ear discharge or blocked ears | | |
| 11 | Sinusitis, frequent head colds, blocked nose, hay fever or other allergies | | |
| 12 | Back, spine or neck injuries, pain or arthritis | | |
| 13 | Fractures or dislocations | | |
| 14 | Head injuries, knocks or falls during sports or other activities, seen a Doctor or Hospitalised for head injuries, blackouts or loss of consciousness | | |
| 15 | Skin disease, eczema or dermatitis | | |
| 16 | Speech impairments or defect | | |
| 17 | Surgical procedures or hospital admission | | |
| 18 | Any other illnesses or injuries not mentioned above in the last 12 months which interfered with or stopped you riding. | | |
| 19 | Have you ever made a claim for Workers' Compensation or had an Impairment Rating? | | |



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If you have answered **'YES'** to any of the medical information questions, please provide further details below in the "Details of Condition" and please ensure you provide the correct reference number.

| Ref Number | Details of Condition |
|---|---|
| | |
| | |
| | |
| | |
| | |

| | | |
|---|---|---|
| Date of last Tetanus Injection / Booster: | | |
| Do you smoke?<br>**(If yes, please provide the number of cigarettes or other tobacco products you smoke per day)* | Yes | No |
| | * | |
| Do you consume alcohol?<br>**(If yes, please provide the number of standard drinks per day)* | Yes | No |
| | * | |

| | | |
|---|---|---|
| Has the applicant ever received any Workcover impairment pay-out/s? | Yes | No |

| Date | Details |
|---|---|
| | |
| | |

**Prescriptions** – please provide details of any oral, injectable or topical medications currently prescribed for you by a Medical Practitioner or which has been prescribed for you by a Medical Practitioner in the past. Also include any of the following items: herbal preparations, vitamins or supplements you use or have used whether prescribed or otherwise.

| **Medication** | **Dosage** | **Reason for Use** | **Prescribing Practitioner** |
|---|---|---|---|
| | | | |
| | | | |



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| | | | |
|---|---|---|---|
| Does the applicant require permission to receive a specified banned substance under specified conditions (AR 142)? | Yes | No | |
| If yes, please attach supporting letter(s). | | Attached | |

**APPLICANT DECLARATION**

1. I consent to HRID collecting health information about me for the purposes of assessing my suitability to grant or retain a licence.
2. I agree to provide all relevant health information regarding my prospective / current licence, including information from other medical practitioners / specialists and my pathology and radiology reports.
3. If it is not reasonable and practicable for me to provide the health information, I authorise consent for HRO's Chief Medical Officer to obtain and collect all relevant health information regarding my prospective / current licence. This includes approval to obtain information from other medical practitioners / specialists and access to all my pathology and radiology reports.
4. I understand that I can gain access to my health information that is collected by HRID.
5. I also provide consent for the HRO's Chief Medical Officer to, at his discretion; discuss the above health information with nominated representatives of the HRID and external health service providers contracted to HRO. I am aware that the information will be used for the purposes of assessing my suitability to grant or retain a licence.
6. I declare that all information that I have provided within this medical report form and any attachments are correct and that I have not withheld any information that is relevant to this medical report form.
7. I declare that I have not provided for the purposes of this medical report form, any false or misleading information. I acknowledge that if I have provided any false or misleading information then I have failed to fulfil the standards necessary to obtain my licence and I am liable to immediate cancellation or suspension of my licence.
8. I declare that if I should be diagnosed with any of the conditions listed within this medical report form, or the circumstances of any of the listed conditions I currently have should change, then I agree to immediately consult with HRO's Chief Medical Officer.
9. I declare that I will comply with the Rules of Racing related to the safety and welfare of riders.
10. I also provide consent for the Declaration of this form to be provided to another Principal Racing Authority upon request, in the event that I accept rides outside of Mauritius.

**Authorisation**

| | Applicant | Witness |
|---|---|---|
| Name: | | |
| Signature: | | |
| Date: | | |



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**Part C Rider Licence – Medical Examination**

This section is to be completed by the medical practitioner performing the Medical.

Applicant Details

| | | | | | |
|---|---|---|---|---|---|
| Full Name: | | | | D.O.B: | |
| Current Age: | Height: | Weight: | B.M.I: (weight ÷ height$^2$) | | |

Examining Doctors Details

| | | | | | |
|---|---|---|---|---|---|
| Family Name: | | | | Given Name: | |
| Practice Name | | | | Provider Number: | |
| Time as Applicants GP Years: | | Months: | | Date Records Held From | / / |
| If you are not the applicant's normal GP, who is? | | | | | |

**Examining Doctors Review of Part B**

Please refer to Part B Medical Information completed by the applicant and confirm and or provide further details

| Ref Number | Details of Condition |
|---|---|
| | |
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| | |
|---|---|
| Date of last Tetanus Injection / Booster: | |



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**Family History**

Please detail family history of illness or disease i.e. Diabetes, Cardio-vascular disease, high blood pressure, Lipid Disorders etcetera.

| Family History |
|---|
| |
| |
| |
| |

**Medical Examination**

**1. Medication Record**

It is extremely important to have a comprehensive list of any medications that the applicant is taking or has recently taken for the following reasons.

- The therapeutic effect of the medication may put a rider at risk when he/she falls (eg. warfarin).
- The side effects, actual or potential of the medication are such that they could interfere with the rider's physical capability, judgement, co-ordination or alertness (eg. antidepressant medication.
- A voluntary or involuntary adjustment of the dosage, administration or absorption of the medication may interfere with the rider's physical capability, judgement, co-ordination or alertness (eg. insulin dependent diabetes, epilepsy)

| Medication | Dosage | Reason for Use | Prescribing Practitioner |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**2. Eyes & Visual Acuity**

Corrective lenses are acceptable if these are soft contact lenses. The minimum requirements with or without corrective lenses are 'good eye' 6/9 or better, 'worse eye' 6/18 or better.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Lids and Cornea – Normal | Yes | | | | No | | | |
| 2. | Visual Acuity for Distance | Right | | | | Left | | | |
| | Uncorrected | 6 / | | | | 6 / | | | |
| | Corrected | 6 / | | | | 6 / | | | |
| | Movement – Normal | ☐ | Y | ☐ | N | ☐ | Y | ☐ | N |
| | Fields (Confrontation test) – Normal | ☐ | Y | ☐ | N | ☐ | Y | ☐ | N |
| | Are contact lenses or spectacles worn? | ☐ | Yes | | | ☐ | No | | |



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| | | | | | | |
|---|---|---|---|---|---|---|
| 3. | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Monocular vision | ☐ | Yes | ☐ | No | |
| | b. Visual field defect – (homonomous hemianopia, bilateral glaucoma, bilateral cataract, bilateral retinopathy etc.) | ☐ | Yes | ☐ | No | |
| | c. Diplopia | ☐ | Yes | ☐ | No | |
| | d. Colour blindness | ☐ | Yes | ☐ | No | |
| | e. Retinal detachment | ☐ | Yes | ☐ | No | |

| **3. Cardiovascular System** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Pulse rhythm and Character – Normal? | ☐ | Yes | ☐ | No | |
| 2. | Heart sounds – Normal? | ☐ | Yes | ☐ | No | |
| 3. | Pulse rate – BPM – Normal? | ☐ | Yes | ☐ | No | |
| 4. | Peripheral pulses – Normal? | ☐ | Yes | ☐ | No | |
| 5. | Blood Pressure | Systolic | | Diastolic | | |
| | Standing | | | | | |
| | Sitting | | | | | |
| 6. | If BP is greater than 140 (systolic) or 90 (diastolic) record BP after applicant has been lying down for 5 minutes | | | | | |
| 7. | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Ischaemic heart disease/angina | ☐ | Yes | ☐ | No | |
| | b. Heart failure | ☐ | Yes | ☐ | No | |
| | c. Myocardial infarction | ☐ | Yes | ☐ | No | |
| | d. By-pass grafting | ☐ | Yes | ☐ | No | |
| | e. Angioplasty | ☐ | Yes | ☐ | No | |
| | f. Cardiac transplant | ☐ | Yes | ☐ | No | |
| | g. Hypertension | ☐ | Yes | ☐ | No | |
| | h. Dysrhythmias | ☐ | Yes | ☐ | No | |
| | i. Pacemakers | ☐ | Yes | ☐ | No | |
| | j. Cardiac valvular disease | ☐ | Yes | ☐ | No | |
| | k. Cardiomyopathies | ☐ | Yes | ☐ | No | |



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| | | | | | | |
|---|---|---|---|---|---|---|
| | l. Congenital heart disease | ☐ | Yes | ☐ | No | |
| | m. Marfan syndrome | ☐ | Yes | ☐ | No | |
| | n. Treatment with anticoagulants | ☐ | Yes | ☐ | No | |
| | o. Peripheral vascular disease | ☐ | Yes | ☐ | No | |
| | p. Chronic pericarditis | ☐ | Yes | ☐ | No | |
| | q. Aneurysm | ☐ | Yes | ☐ | No | |

## 4. Respiratory System

Asthma controlled with inhalers is not normally a concern. Applicants required to take oral steroids or who are severely debilitated by their condition will be required to attend a consultant for a full review. If there is a history or asthma or abnormal respiratory history / examination then a spirometer is required.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Respiratory system – Normal? | ☐ | Yes | ☐ | No | |
| 2. | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Asthma | ☐ | Yes | ☐ | No | |
| | b. Chronic obstructive airway disease (COAD) | ☐ | Yes | ☐ | No | |
| | c. Spontaneous pneumothorax – single episode | ☐ | Yes | ☐ | No | |
| | d. Spontaneous pneumothorax – recurrent episode | ☐ | Yes | ☐ | No | |
| | e. Emphysema | ☐ | Yes | ☐ | No | |
| | f. Respiratory disease affecting performance | ☐ | Yes | ☐ | No | |

## 5. Musculoskeletal System

Fractures and dislocations are common in race riding. Before applying to ride, or return to riding, the applicant must have an appropriate range of pain free movement, radiological evidence of a sound bony union, clearance from an orthopaedic surgeon and be able to show that his/her ability to ride safely is unaffected. No rider may wear a plaster cast, back slab, fibreglass support, prosthesis, harness or similar appliance. Fracture of the skull, fractures of the spine and disc injuries are of particular concern and these applicants may be required to attend for examination by a HRID Medical Consultant.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Spinal Function – Normal? | ☐ | Yes | ☐ | No | |
| 2. | Strength and range of movement in upper or lower extremities – Normal? | ☐ | Yes | ☐ | No | |
| 3. | Joints – Normal? | ☐ | Yes | ☐ | No | |
| 4. | Limbs – Normal? | ☐ | Yes | ☐ | No | |
| 5. | Any orthopaedic appliances worn? | ☐ | Yes | ☐ | No | |



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| | | | | | | |
|---|---|---|---|---|---|---|
| 6. | Grip Strength – Normal? | ☐ | Yes | ☐ | No | |
| 7. | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Loss of digit | ☐ | Yes | ☐ | No | |
| | b. Fractures | ☐ | Yes | ☐ | No | |
| | c. Fracture of the skull and spine | ☐ | Yes | ☐ | No | |
| | d. Dislocation of the Acromioclavicular (A/C joint) | ☐ | Yes | ☐ | No | |
| | e. Dislocation or subluxed shoulder | ☐ | Yes | ☐ | No | |
| | f. Rheumatoid arthritis | ☐ | Yes | ☐ | No | |
| | g. Spondylolisthesis | ☐ | Yes | ☐ | No | |
| | h. Disc injury | ☐ | Yes | ☐ | No | |
| | i. Joint replacement | ☐ | Yes | ☐ | No | |
| | j. Internal metal fixation | ☐ | Yes | ☐ | No | |

## 6. Neurological Disorders

**CONVULSIONS**

Mauritius Standards are broadly in line with the current international criteria – fit free for 10 years; off all anti-convulsant medication for 10 years and having no further liability to convulsions.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Chronic migraine | ☐ | Yes | ☐ | No | |
| | b. Chronic neurological disorders (Parkinson's disease, multiple sclerosis, etc.) | ☐ | Yes | ☐ | No | |
| | c. Chronic Meniere's, vertigo or labyrinthitis | ☐ | Yes | ☐ | No | |
| | d. Cerebrovascular disease | ☐ | Yes | ☐ | No | |
| | e. Meningitis | ☐ | Yes | ☐ | No | |
| | f. Intracranial aneurysm | ☐ | Yes | ☐ | No | |
| | g. A-V malformation after a bleed | ☐ | Yes | ☐ | No | |
| | h. Narcolepsy | ☐ | Yes | ☐ | No | |
| | i. Unexplained loss of consciousness | ☐ | Yes | ☐ | No | |
| | j. Treatment with anticoagulants | ☐ | Yes | ☐ | No | |
| | k. Sub-arachnoid haemorrhage (see Epilepsy /single seizure) | ☐ | Yes | ☐ | No | |



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| | | | | | | |
|---|---|---|---|---|---|---|
| | l. Intracranial haematoma (see Epilepsy /single seizure) | ☐ | Yes | ☐ | No | |
| | m. Serious head injury (see Epilepsy /single seizure) | ☐ | Yes | ☐ | No | |
| | n. Craniotomy / burr hole surgery Following any cranial fracture or surgery the integrity and / or strength of the skull **must not** be significantly compromised | ☐ | Yes | ☐ | No | |
| | o. Has the applicant ever experienced a convulsion? | ☐ | Yes | ☐ | No | |
| | p. Epilepsy single seizure:<br>• Following acute head injury or intracranial surgery. An applicant may be reviewed after a minimum of 12 months provided, he or she has been without all anti-epileptic medication and has been free of fits during that period. | ☐ | Yes | ☐ | No | |
| | q. Epilepsy:<br>Applicant has been free of epileptic attack for at least 10 years.<br>Applicant has not taken any epileptic medications during this 10-year period<br>Applicant does not have a continuing liability to epileptic seizures. | ☐ | Yes | ☐ | No | |

## 7. Hearing, Ears and Nose

Hearing should be within the range 500 – 2000 c/second there must be no hearing loss greater than 35 Dba in either ear.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. | Nose – Normal | ☐ | Yes | | ☐ | No | | | |
| 2. | Ears | Right | | | | Left | | | |
| | External auditory canal – Normal | ☐ | Y | ☐ | N | ☐ | Y | ☐ | N |
| | Tympanic membrane – Normal | ☐ | Y | ☐ | N | ☐ | Y | ☐ | N |
| | Conversational voice @ 2.5 metres binaural – Normal | ☐ | Y | ☐ | N | ☐ | Y | ☐ | N |
| | Fields (Confrontation test) – Normal | ☐ | Y | ☐ | N | ☐ | Y | ☐ | N |
| 3. | Does the applicant have a medical history that includes any of the following? | | | | | | | | |
| | a. Bilateral total deafness | ☐ | Yes | | ☐ | No | | | |



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|---|---|---|---|---|---|---|
| | b. One side total deafness with contralateral air bone conduction loss greater than 35 dBA | ☐ | Yes | ☐ | No | |
| | c. Any disorder in the eardrum leading to a binaural hearing loss greater than 35 dBA | ☐ | Yes | ☐ | No | |
| | d. Acute infection | ☐ | Yes | ☐ | No | |
| | e. Perforated eardrum | ☐ | Yes | ☐ | No | |
| | f. Chronic suppurating otitis media | ☐ | Yes | ☐ | No | |
| | g. Otosclerosis | ☐ | Yes | ☐ | No | |
| | h. Ear Prosthesis | ☐ | Yes | ☐ | No | |

| **8. Endocrine and Metabolic Disorders** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Does the applicant have a medical history that includes diabetes? | ☐ | Yes | ☐ | No | |
| 2. | If the applicant is diabetic, is he/she | ☐ | Yes | ☐ | No | |
| | a. Insulin dependent | ☐ | Yes | ☐ | No | |
| | b. Requiring oral medication | ☐ | Yes | ☐ | No | |
| | c. Controlling the diabetes by diet | ☐ | Yes | ☐ | No | |
| 3. | Does the applicant have a medical history that includes any of the following? | ☐ | Yes | ☐ | No | |
| | d. Thyroid disease | ☐ | Yes | ☐ | No | |
| | e. Diabetes insipidus | ☐ | Yes | ☐ | No | |
| | f. Adrenal disorders | ☐ | Yes | ☐ | No | |

| **9. Digestive system, Gastrointestinal and Abdominal Disorder** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Oropharynx – Normal? | ☐ | Yes | ☐ | No | |
| 2. | Spleen – Normal? | ☐ | Yes | ☐ | No | |
| 3. | Liver – Normal? | ☐ | Yes | ☐ | No | |
| 4. | Other abdominal organs – Normal? | ☐ | Yes | ☐ | No | |
| 5. | Is hernia present? | ☐ | Yes | ☐ | No | |
| 6. | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Acute gastric erosion | ☐ | Yes | ☐ | No | |
| | b. Chronic gastritis | ☐ | Yes | ☐ | No | |



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|---|---|---|---|---|---|---|
| | c. Active peptic ulcer | ☐ | Yes | ☐ | No | |
| | d. Hiatus hernia | ☐ | Yes | ☐ | No | |
| | e. Inguinal hernia | ☐ | Yes | ☐ | No | |
| | f. Haemorrhoids, anal fissure, fistulae | ☐ | Yes | ☐ | No | |
| | g. Colostomy, ileostomy | ☐ | Yes | ☐ | No | |
| | h. Colitis (ulcerative or Crohn's) | ☐ | Yes | ☐ | No | |
| | i. Cirrhosis | ☐ | Yes | ☐ | No | |
| | j. Chronic pancreatic | ☐ | Yes | ☐ | No | |
| | k. Chronic active hepatitis | ☐ | Yes | ☐ | No | |

| **10. Genitourinary and Renal Disorders** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Urine Test | | | | | |
| a. Glucose – Normal? | | ☐ | Yes | ☐ | No | |
| b. Albumin – Normal? | | ☐ | Yes | ☐ | No | |
| c. Blood – Normal? | | ☐ | Yes | ☐ | No | |
| d. Other abnormalities? | | ☐ | Yes | ☐ | No | |
| 2. | Testes – any abnormality affecting fitness? | ☐ | Yes | ☐ | No | |
| 3. | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Chronic renal failure | ☐ | Yes | ☐ | No | |
| | b. Renal transplant | ☐ | Yes | ☐ | No | |
| | c. Nephritis | ☐ | Yes | ☐ | No | |
| | d. Kidney stones | ☐ | Yes | ☐ | No | |
| | e. Prostatitis | ☐ | Yes | ☐ | No | |
| | f. Single kidney or horse shoe kidney | ☐ | Yes | ☐ | No | |

| **11. Skin** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Skin – Normal? | ☐ | Yes | ☐ | No | |
| 2. | Any body marks or scars? | ☐ | Yes | ☐ | No | |

| **12. Central Nervous System** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Pupillary Reflexes – Normal? | ☐ | Yes | ☐ | No | |
| 2. | Tendon / Reflexes – Normal? | ☐ | Yes | ☐ | No | |



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| | | | | | | |
|---|---|---|---|---|---|---|
| 3. | Cranial Nerves – Normal? | ☐ | Yes | ☐ | No | |
| 4. | Any signs of gross sensory disturbances? | ☐ | Yes | ☐ | No | |
| 5. | Any sign of paresis, tremor or tics? | ☐ | Yes | ☐ | No | |
| 6. | Is the applicant's speech normal? | ☐ | Yes | ☐ | No | |

| **13. Psychiatric Disorders** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Does the applicant have a medical history that includes any of the following? | | | | | |
| | a. Neuroses | ☐ | Yes | ☐ | No | |
| | b. Psychoses (manic depressive illness, schizophrenia) | ☐ | Yes | ☐ | No | |
| | c. Dementia (eg. pre-senile, Alzheimer's disease) | ☐ | Yes | ☐ | No | |
| | d. Personality disorder (eg. post head injury, psychopathic disorders) | ☐ | Yes | ☐ | No | |
| | e. Dependence (or chronic abuse) – alcohol, drugs, solvent | ☐ | Yes | ☐ | No | |

| **14. Infectious Disorders** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Does the applicant have a medical history that includes any of the following? | | | | | |
| a. Tuberculosis | | ☐ | Yes | ☐ | No | |
| b. Hepatitis | | ☐ | Yes | ☐ | No | |
| c. HIV positive | | ☐ | Yes | ☐ | No | |
| d. AIDS syndrome | | ☐ | Yes | ☐ | No | |

| **15. Haematology** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Does the applicant have a medical history that includes any haemorrhagic disorders? | ☐ | Yes | ☐ | No | |
| 2. | Are lymph glands normal? | ☐ | Yes | ☐ | No | |

| **16. Female Applicants Only** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Dysmenorrhoea? | ☐ | Yes | ☐ | No | |
| 2. | Menorrhagia? | ☐ | Yes | ☐ | No | |



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| | | | | | | |
|---|---|---|---|---|---|---|
| 3. | Has the applicant been pregnant? If so, is she: | ☐ | Yes | ☐ | No | |
| | a. More than three months pregnant? | ☐ | Yes | ☐ | No | |
| | b. Had a caesarean section in the past 16 weeks? | ☐ | Yes | ☐ | No | |
| 4. | Has the applicant had a hysterectomy? If so, when? | ☐ | Yes | ☐ | No | |

| **17. Neoplasia** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Does the applicant have a medical history that includes neoplasm? | ☐ | Yes | ☐ | No | |

| **18. Other** | | | | | | |
|---|---|---|---|---|---|---|
| 1. | If the applicant is over 50 years of age, please consider but do not perform – Will need fasting blood lipids, glucose and stress ECG. | ☐ | Yes | ☐ | No | |

**EXAMINING DOCTOR NOTE:**

Parts A, B, C and the Declaration must be completed and returned to the applicant who must forward to HRID to progress their application.

**A copy of this entire document must be retained by the examining doctor for their medical records**.



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**DECLARATION BY MEDICAL PRACTITIONER**

**Jockey Medical Examination**

| | | | |
|---|---|---|---|
| Full Name: | | | |
| D.O.B: | | Weight: | |

I have today personally examined the above applicant in accordance with the requirements of the HRID Jockey Medical Report and hereby declare that:

| | |
|---|---|
| ☐ | I am the applicant's regular treating GP; or |
| ☐ | I am not the applicant's regular treating GP but I have reviewed the applicant's medical history and I believe this to be a true medical record. |

**AND**

*(Please select as appropriate):*

| | |
|---|---|
| ☐ | I found nothing unfavourable in the applicant's history or examination. I refer the applicant for consideration by the HRID. |
| ☐ | In my opinion, there are medical reasons why the applicant cannot race ride and I recommend that the applicant be referred for further examination. |

**Notes for the Chief Medical Officer**

| **Notes** | |
|---|---|
| | |
| **Additional Information Requested** | **Expected Delay** |
| | |



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**Doctors Details**

| | | | |
|---|---|---|---|
| Family Name: | | Given Name: | |
| Provider Number: | | | |
| Practice Name: | | | |
| Address: | | | |
| | | | |
| Contact Telephone (Home): | | Mobile: | |
| Email Address: | | | |

*And/Or Practice/Provider Stamp below:*

| |
|---|
| |

| | |
|---|---|
| Examining Doctors Name: | |
| Examining Doctors Signature: | |
| Date: | |

**To be completed by the Chief Medical Officer:**

| | | |
|---|---|---|
| ☐ | **YES** | Following consideration of the information detailed in this report and all other relevant information, in my opinion the applicant **IS FIT** to race ride without restriction and for the issue of a licence/permit applied for. I do not consider any further reports or tests are required of this applicant. |
| ☐ | **NO** | Following consideration of the information detailed in this report and all other relevant information, in my opinion the applicant **IS NOT FIT** to race ride or for the issue of the licence/permit applied for and I recommend that further examination [as detailed below] is required. |



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