

Organisers are responsible for the completion of this form and in all cases at Motorsport Australia authorised events where any person suffers an injury and/or any person is given medical attention by first aid or medical personnel.

Additional reports (eg. Vehicle damage and/or incident reports) must be attached to this form.

 **OFFICE USE**



Please submit to:
permits@motorsport.org.au



or post to:
Member Services
PO Box 172
Canterbury VIC 3126

Need help? Contact 1300 883 959

DRIVER'S NAME

STEWARDS SIGNATURE		DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
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SECRETARY SIGNATURE		DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
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 **INJURED'S DETAILS**

SURNAME	GIVEN NAMES
DATE OF BIRTH - -	GENDER
DRIVER'S CLUB	
ADDRESS	
SUBURB	STATE POSTCODE
EMAIL	
MOBILE	PHONE
CAR NUMBER	LICENCE NO.
ROLE AT EVENT	<input type="checkbox"/> DRIVER <input type="checkbox"/> CO-DRIVER <input type="checkbox"/> OFFICIAL <input type="checkbox"/> PIT CREW <input type="checkbox"/> SPECTATOR
	<input type="checkbox"/> OTHER (PLEASE SPECIFY)

 **EVENT/INSPECTION DETAILS**

NAME OF EVENT		
VENUE/ LOCATION		
PERMIT NO. (IF APPLICABLE)	STATE	TIME OF INCIDENT
EVENT DATE - -		

 **HEALTH STATEMENT**
TO BE COMPLETED BY MEDICAL PERSONNEL

SHOULD* SHOULD NOT ...BE SUSPENDED PENDING FURTHER EXAMINATION.

**Note: if medical personnel consider licence should be suspended, it is to be immediately submitted to the Stewards of the Meeting with this form.*



FURTHER DETAILS

INJURY	PERSONAL INJURY	NO PERSONAL INJURY	
TREATMENT LOCATION	COLLISION SCENE	MEDICAL CENTRE	OTHER
ARRIVAL METHOD	ON FOOT	AMBULANCE	NON MEDICAL VEHICLE
CONDITION ON INITIAL PRESENTATION			

CHIEF STEWARD SIGNATURE		DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
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CLERK OF THE COURSE SIGNATURE		DATE	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>
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STATEMENT BY MEDICAL PERSONNEL

WHERE SEEN

CONDITION ON INITIAL PRESENTATION

WHAT (IF ANY) TREATMENT WAS PERFORMED?

SUBSEQUENT TREATMENT RECOMMENDED

URGENT

NON URGENT

HOME REST

OWN DOCTOR

HOSPITAL

OTHER (PLEASE SPECIFY)

NAME OF MEDICAL
PERSONNEL

EMAIL

MOBILE

SIGNATURE

DATE

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