

# 2026 MEDICAL FORM



## MEDICAL EXAMINATION FORM FOR COMPETITION LICENSE

### IMPORTANT NOTES:

1. The examination should be performed by a doctor familiar with the applicant's medical history or by the applicant's regular doctor.
2. In the event of serious injury or illness following the issue of this medical certificate, a further examination and medical certificate (re-certification) are required.
3. The examining doctor must be aware that the person to be examined is applying for a license to participate in motorsport events.

Full Name:

Address:

Nationality:  NRIC / Passport No:

Date of Birth:  Age:  Sex:

Tel No:

Emergency Contact Name:  Emergency Tel No:

## TO BE COMPLETED BY EXAMINING DOCTOR

(For any abnormal findings please do give in written, the findings in the column provided below each systemic examination)

### 1. Medical History (any known medical illness or conditions)

If yes, provide further information (e.g., condition(s), current status, medications, dates of diagnoses, treatments, outcomes):

YES / NO

### 2. Surgical History

Have you undergone any surgeries?

If yes, provide further information

(including dates, types of surgeries, complications):

YES / NO

### 3. Mental Health

Any evidence of a mental health condition, past or present?

If yes, provide further information:

YES / NO

### 4. Medications and Allergies

List all current medications (including prescription and over-the-counter drugs) with dosages and frequencies:

Do you have any allergies to medications, food, or environmental factors?

If yes, list:

YES / NO

# MEDICAL FORM 2026

## 5. General

Blood Pressure:

Pulse Rate:

Rhythm:

Height:

Weight:

### Blood Group (COMPULSORY TO FILL IN)

## 6. Cardiovascular System

Auscultation: \_\_\_\_\_

Murmurs: YES

NO

→ **ECG:** Required for applicants 40 years and above; validity for 2 years.

→ **FULL STRESS ECG:** Required for applicants 45 years and above; validity for 2 years or if significant risk factors/history of cardiac disease.

Remarks / Any abnormal findings:

## 7. Respiratory System

Respiratory Rate: \_\_\_\_\_

Lung Sounds: \_\_\_\_\_

Pulmonary Function Tests (if indicated):

Remarks / Any abnormal findings:

## 8. Gastrointestinal System

Examination of Abdomen: \_\_\_\_\_

Hernia Check: \_\_\_\_\_

Liver and Spleen:

Remarks / Any abnormal findings:

## 9. Genitourinary System

Urine – Albumin/Protein:

Glucose:

Blood:

Urine – Drug Test (Required for International Licence Application):

Remarks / Any abnormal findings:

# MEDICAL FORM 2026

**10. Spine and musculoskeletal:**

Upper Limbs: (Range of motion, strength, any signs of injury or impairment)

Lower Limbs: (Range of motion, strength, any signs of injury or impairment)

Spine: (Range of motion, any signs of injury or impairment)

**Remarks / Any abnormal findings:**

**11. Neurological System (Including Reflexes):**

Mental Status: \_\_\_\_\_

Cranial Nerves: \_\_\_\_\_

Motor Function: \_\_\_\_\_

Sensory Function: \_\_\_\_\_

Reflexes: \_\_\_\_\_

Coordination and Balance: \_\_\_\_\_

**Remarks / Any abnormal findings:**

**12. Visual Examination:**

Glasses: YES / NO

Contact Lenses: YES / NO

**Visual Acuity**

Distance Vision	Uncorrected	Corrected
Right Eye		
Left Eye		

Near Vision	Uncorrected	Corrected
Right Eye		
Left Eye		

**Colour Vision:**

(As tested with Ischiara's chart)

**Field of Vision:**

(With both eyes open together)

Laterally: ..... degrees

Vertically: ..... degrees

**Remarks / Any abnormal findings:**

**13. Hearing:** Left      Normal / Abnormal  
                            Right      Normal / Abnormal

# MEDICAL FORM 2026

**14. Any Additional information / Observations / Recommendations:**

**Certification**

*I hereby certify that the above-named applicant has been examined by me today and found to be:*

<b>FIT TO RACE</b>	<input type="checkbox"/>
<b>UNFIT TO RACE</b>	<input type="checkbox"/>
<b>REFER TO MEDICAL CHAIRMAN/MEDICAL COMMISSION FOR FURTHER EVALUATION</b>	<input type="checkbox"/>

(Please tick)

**DOCTOR INFORMATION**

Are you the regular medical attendant of the applicant?      YES       NO

Name of Clinic

Address

Tel

Doctor's Name

Doctor's Signature

Date

Official STAMP

Any fee charged for the completion of this examination or associated with it is the responsibility of the applicant. The applicant is requested to forward the completed form immediately to:

**2<sup>nd</sup> Floor Nizra Building, 8 Jalan Seri Penchala,  
Kampung Sungai Penchala, 60000 Kuala Lumpur.  
Motorsports Association of Malaysia**