COMPETITOR MEDICAL INFORMATION FORM

You are requested, in your own interest, to complete this document, which will be held at Race Control for use by the Chief Medical Officer

PERSONAL DETAILS

SURNAME:		ID/PASSPORT NO:	
FULL FIRST NAME(S):			
RESIDENTIAL ADDRESS:			

HOME TEL NO:		WORK TEL NO:		CELL NO:	

CONTACT PERSON IN THE EVENT OF AN EMERGENCY

NAME:		RELATIONSHIP (i.e. Wife, etc.)			
HOME TEL NO:		WORK TEL NO:		CELL NO:	

MEDICAL AID / MEDICAL INSURANCE DETAILS FOR HOSPITAL ADMISSION PURPOSES

I hereby agree to be attended to by doctors/paramedics if I am injured and wish to be transported to the type of hospital indicated. **PLEASE NOTE THAT IF YOU HAVE INDICATED THAT YOU WISH TO BE TREATED AT A PRIVATE FACILITY IT IS ESSENTIAL THAT YOU COMPLETE THE FOLLOWING SECTION AND PROVIDE PROOF OF MEDICAL AID / MEDICAL INSURANCE TO GUARANTEE YOUR ADDMISSION TO A PRIVATE FACILITY FAILING WHICH YOU WILL BE TRANSPORTED TO THE NEAREST APPROPRIATE FACILITY**		**PRIVATE**	
		STATE	
Do you currently hold MSA Competitor Insurance?		**YES**	**NO**
Please mark the maximum medical benefit for which you are currently insured by MSA.		**R150,000**	**R250,000**	**R500,000**

MEDICAL AID SCHEME NAME:		TYPE OF SCHEME:	
MEMBERSHIP NUMBER:		PRINCIPAL MEMBER:	
PERSONAL (HOME) DOCTOR:		CONTACT NUMBER:	

MEDICAL INFORMATION

MEDICATION/MEDICAL CONDITION(S):			
ALLERGIES:		BLOOD GROUP (IF KNOWN)	
SIGNATURE		PARENT/LEGAL GUARDIAN IF UNDER 21 YEARS OF AGE	