

Original Date:
Dates Revised:

PERFECT KOMBINATION M. C.

Application

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Make of Motorcycle		Model of Motorcycle	
Cc's	TAG NUMBER	COLOR	

INSURANCE INFORMATION

Name of Insurance		
Do you have a	<input type="checkbox"/> M C License	Were you previously in another M C Club? If so what was the name of the club.
	<input type="checkbox"/> Lerner's	How many years have you been riding?
	<input type="checkbox"/> Other	Did you take the M C safety course?

List any medical problems that you may have

IN CASE OF EMERGENCY, WHO TO CONTACT

NAME	ADDRESS	TELEPHONE NUMBER

ARE YOU ALLERGIC TO ANY MEDICATIONS

IS THERE ANY OTHER INFORMATION YOU THINK WE SHOULD KNOW ABOUT YOU?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please turn over and use the back.....

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

PLEASE SIGN THIS APPLICATION AND CONTACT OUR SECRETARY BY EMAIL FOR FURTHER INSTRUCTIONS AT JNIC17@HOTMAIL.COM

DATE