## APPLICATION FOR ONE/TWO DAY ORPA COMPETITION LICENCE

##  FULL NAME:…............................................................................................................ADDRESS: ..............…………...................................................................................

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##  ...............................................................POST CODE: .........................DATE OF BIRTH:……….............. MALE/FEMALE\* deleteI wish to purchase a one/two day event adult competition licence for the following event (*included in event entry fee*):

## Event: King of the Hills Venue: Middlehills, Derbyshire

## Organising Club: Vintage Dirt Bike

##  *(Tick as appropriate)*

## Grass Sprint 8th July One Day Licence

## Hare and Hounds 9th July One Day Licence

## Both of the above events 8/th July Two Day Licence

## Medical Declaration\*1. Have you been rejected or accepted at increased premiums for life assurance on medical grounds? YES/ NO2. Have you been treated for, do you now have, or have you ever had any of the following:(a) Head injury? ` YES / NO(b) Unconsciousness or concussion (within the last 28 days)? YES / NO(c) High blood pressure/heart disease or disorder? YES / NO(d) Dizziness, fainting spells, epilepsy, fits or blackouts? YES / NO(e) Disease, injury or operation to either eye? YES / NO(f) Do you have any vision defect or loss of sight in either eye? YES / NO(g) Do you have any condition which affects movement of arms/legs? YES / NO(h) Do you have any false or missing limbs? YES / NO*\* If you have answered YES to any of the above, please give further details:*………………………………..........................................................................................................

## ..........................................................................................................................................................

## I certify that the above statements are true and accurate and I understand my licence may be invalid/withdrawn should any prove to be so. I also authorise any hospital or medical practitioner to furnish information relative to my condition to ORPA. Signature:…………....................................................................Date:………………

## Signature of Parent/Guardian:……………………………..............(if under 18 years of age)