

**Date:** [Insert Date]

**To:** [Sanctioning Body/Racing Organization Name]

**Attn:** Medical Licensing Department

**Re:** Medical Fitness Certification for Motor Racing

**Driver Information:**

Name: [Driver Full Name]

Date of Birth: [MM/DD/YYYY]

License Number (if applicable): [Insert Number]

To Whom It May Concern,

I, Dr. [Physician Name], have conducted a formal medical evaluation of [Driver Full Name] on [Date of Examination] to determine their physical and mental fitness to participate in competitive motor racing activities.

The evaluation included a review of the patient's medical history and a physical examination covering the following areas:

- Visual acuity and color vision
- Cardiovascular health and blood pressure
- Neurological function and reflexes
- Musculoskeletal strength and mobility
- Hearing and vestibular balance

Based on my findings and the medical standards provided by [Insert Organization Name, e.g., FIA/SCCA/NASA], I certify that:

[Select One:]

The applicant meets all medical requirements and is **FIT** to participate in motor racing.

The applicant is **FIT** to participate with the following restrictions: [Insert Restrictions].

The applicant is currently **UNFIT** to participate.

This certification is valid until [Insert Expiration Date].

Sincerely,

[Signature]

**Physician Name:** [Print Name]

**Medical License Number:** [Insert Number]

**State/Province:** [Insert Location]

**Clinic/Hospital Name:** [Insert Name]

**Phone Number:** [Insert Phone]