THE FOUR WHEEL DRIVE CLUB OF W.A. (Inc).

P.O. BOX 316, INGLEWOOD W.A. 6932.

ABN: 31 218 745 475. E-mail: clubinfo@4wdclubwa.com Website: www.4wdclubwa.com

Personal and Medical Details

The Club suggests that relevant personal and medical details of Members and other participants should be recorded in the event of an accident or personal injury. These details are to remain private except when disclosed to persons rendering first aid or medical assistance.

Personal and medical information should be recorded for each person in your vehicle. Each person's document should be sealed in a separate envelope with the name on the front, and can be stored in the glove box.

We'd suggest that two (2) copies be made. While one copy remains in the glove box, the other can be handed to the Trip Leader for safekeeping when attending a trip. The sealed envelopes will be returned at the end of the trip.

Sincerely,

Trips Committee Chairman, Trips coordinator.

The Four Wheel Drive Club of W.A. (Inc).

Email: clubinfo@4wdclubwa.com

Legal Disclaimer: This message contains privileged and confidential information intended only for the use of the addressee named above. If you are not the intended recipient of this message, you are hereby notified that you may not disseminate, copy or take any action based on the contents thereof; kindly inform the sender immediately.

While every care has been taken in preparing this document, no representation, warranty or undertaking (expressed or implied) is given and no responsibility nor liability is accepted by any member of The Four Wheel Drive Club of W.A. (Inc) as to the accuracy of the information contained herein, or for any loss arising from reliance on it.

Personal and Medical Details

ARE YOU AN AUSTRALIAN RESIDENT? ☐ YES ☐ No	
If **NO**, where are you from and what visa do you hold, etc.	Visa Arrival Date: / /
Details:	

If you have been in hospital in the last 12 months, especially in the last 7 days please give details:

PERSONAL DETAILS					
Surname:			Name (s):		
Maiden Name:			Preferred Name:		
			Date of Birth:		
Title:	**Mr Mrs Miss Dr**	**Gender:**	**M F**	**Marital Status:**	**M NM D D/F W**
STREET ADDRESS					
Address:					
Suburb:		State:		Post Code:	
POSTAL ADDRESS					
Address:					
Suburb:		State:		Post Code:	
PREVIOUS ADDRESS					
Address:					
Suburb:		State:		Post Code:	
Mobile:		Home:		Work:	
State or Country of Birth:			Aboriginal / Torres Strait Islander / Both / Neither		
Main Language Spoken (other than English):				Interpreter Required: Y N	
Occupation:			Religion:		

NEXT OF KIN		
Surname:		Name:
	Relationship:	
STREET ADDRESS		
Address:		
Suburb:	State:	Post Code:
Mobile:	Home:	Work:

DOCTOR		
Surname:		Name:
STREET ADDRESS		
Address:		
Suburb:	State:	Post Code:
Mobile:	Home:	Work:

Privacy Statement: - Personal and medical information collected on this form are to be used solely in the event of an accident or personal injury. Details are not to be disclosed, sold or passed on to any third party, with the exception of the persons providing first aid and medical assistance.

Personal and Medical Details

MEDICARE AND PRIVATE HEALTH INSURANCE		
MEDICARE No:	Ref No:	Expiry: /
Dept. of Veterans No:	Colour: Gold / White	Expiry: /
PENSION CARD No:		Grant Date: /
HEALTH CARE CARD No:		Grant Date: /
HEALTH FUND:	TABLE:	
MEMBERSHIP NO:	CONTRIBUTOR NAME:	

WORKERS COMPENSATION DETAILS (If applicable)		
EMPLOYER NAME:		
EMPLOYER ADDRESS		
Address:		
Suburb:	State:	Post Code:
Mobile:	Home:	Work:

EMERGENCY CONTACT DETAILS *(Optional)*	
Note the name and phone number of up to three persons who can be contacted in the event of an emergency. These people should preferably not be resident at your address.	
Name:	Phone:
Name:	Phone:
Name:	Phone:

MEDICAL DETAILS		
Blood Type:		
MEDICATION		
MEDICATION	DOSAGE	PURPOSE OF MEDICATION
KNOWN ALLERGIES		

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Personal and Medical Details

MEDICAL CONDITIONS
Full Name
Signature
Date

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