registration form

Participant's Name:

Date of Birth:

Address:

Telephone:

(h) (w) (m)

Driver's licence: Full Provisional Learners

Current Driver's Licence No:

Car preference: Automatic Manual

Do you have an illness/injury/impairment that impacts on your driving?

Yes No

Do you have a current Workers or Motor Accident Compensation claim?

Yes No

If YES, you will need your treating medical practitioner and/or insurance company, if relevant, to complete the following section of the registration form to give approval for you to participate in the programme.

<u>Treating Medical Practitioner:</u>

Name:
Illness/Injury/Impairment:

Signature:
Date of Approval:

<u>Insurance Company (Workers/Motor Vehicle Accident Compensation):</u>

Name:
Date of Approval:

Send to Back in the Drivers Seat, PO Box 103, Hobart, Tasmania, 7000.