



Western Australian Recreational Skipper's Ticket Application for Eyesight Test

Applicant's Details

Surname: _____ First Name: _____ Other Names: _____

Sex: _____ Date of Birth: _____

Residential Street Number/Lot: _____ Residential Street Name: _____

Suburb: _____ Postcode: _____

Telephone Home: _____ Work: _____ Mobile: _____

The Optometrist / Medical Practitioner

This examination is to assess and to determine whether the applicant's eyesight meets a minimum correct vision standard of at least 6/12, in at least one eye.

I _____ of _____
(Optometrist / Medical Practitioner) (address)

Work Telephone _____, being a registered Optometrist or Medical Practitioner in the state of _____ tested the above candidate on ___ / ___ / ___

The results of the examination are listed below:

Results of Examination

Letter Test	Right Eye	Left Eye
Without using any aids to vision	6	6

Letter Test	Right Eye	Left Eye
With aids to vision (If applicable)	6	6

Optometrist / Medical Practitioner Declaration

I, _____ being a registered Optometrist or Medical Practitioner, having this day examined the above named applicant, certify that the above applicant HAS / HAS NOT meet the minimum correct vision standard of at least 6/12, in at least one eye.

Signed: _____ Date: ___ / ___ / ___
(Optometrist / Medical Practitioner)



Western Australian Recreational Skipper's Ticket Declaration of Medical Fitness

Applicant's Details

Surname: _____ First Name: _____ Other Names: _____

Sex: _____ Date of Birth: _____

Residential Street Number/Lot: _____ Residential Street Name: _____

Suburb: _____ Postcode: _____

Telephone Home: _____ Work: _____ Mobile: _____

Declaration of Medical Fitness for the Western Australian Recreational Skipper's Ticket

A serious medical condition could conceivably affect the ability to safely operate a recreational vessel. A self declared medical statement is required before obtaining the Western Australian Recreational Skipper's Ticket. The applicant named on this form has advised the Department that he/she may suffer from the condition/s indicated below and that it could affect their ability to operate a motor vessel safely.

- Epilepsy, Fits, Giddiness, Fainting, Seizures Heart Disease High/Low Blood Pressure
- Arthritis Diabetes any physical or mental disability that could affect their ability to operate a motor vessel safely

As a result of this advice, a Medical Practitioner is required to complete the section below declaring the applicant is medically fit or unfit to operate a recreational motor boat.

The Medical Practitioner

I _____ being a registered Medical Practitioner, declare that as a result of my examination and the statements made by the above named patient, in accordance with the relevant National Medical Standards as set out in *Assessing Fitness to Drive 2003*, find the above named patient is mentally and physically fit unfit (*tick appropriate box*) to operate a recreational motor boat.

Name of Medical Practitioner: _____

Contact Number: _____ Signature: _____ Date: _____