NATIONAL RIFLE ASSOCIATION OF AMERICA
COMPETITIVE SHOOTING SPORTS
11250 WAPLES MILL ROAD
FAIRFAX, VIRGINIA 22030

Phone: 703-267-1491
adaptiveshooting@nrahq.org
DO NOT FAX THIS FORM

Applicant Name: _____ **NRA Member #** _____

Date of Birth: _____ **Please List Your Shooting Discipline:** _____

INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION
Temporary Information Authorization and Release

Temporary Release of Medical Information: I, _____, hereby authorize *(Insert Physician's full name, degree {ie., D.O., M.D., D.D.S., etc.} and address on the following blank lines)*
_____
_____to release to the National Rifle Association's Protest Committee the information outlined below and on my competitor application. I understand that I may revoke this Information Authorization and Release at any time, except to the extent that the covered entity (my health care provider) has taken action in reliance on this Authorization and Release. I understand that my health care provider may not condition treatment, payment, enrollment or eligibility for benefits on the authorization based upon my signing, or refusing to sign, this Release.

Applicant Signature:_____Date:_____

DEAR DOCTOR: Thank you for your assistance in providing this information. Please note:

- Complete all sections; if particular condition is not present, please check "no".
- It is incumbent upon the applicant to provide corroborating information as to how his/her condition affects his/her ability to participate in the shooting sports.
- Please include any relevant documentation with this form: (ie: copies of x-rays)

I. Diagnosis – please give a brief explanation of patient's condition

_____

II. Duration of Diagnosis/Prognosis for Recovery – please give a brief statement

_____

_____

Pertinent Exam Findings

a. Muscle Weakness: ☐ No ☐ Yes; if yes where?_____

Please circle severity: mild moderate severe

b. Visual Impairment: ☐ No ☐ Yes; Is it correctable with lenses?: Yes No Partial

Visual Acuity:	*Right*	*Left*
with corrective lenses:		
without corrective lenses:		

c. Pain: ☐ No ☐ Yes; if yes site & severity:_____

d. Sensory Loss: ☐ No ☐ Yes; if yes site & severity:_____

e. Joint Contracture: ☐ No ☐ Yes; please circle severity: mild moderate severe

f. Bone/Joint Abnormalities: ☐ No ☐ Yes

III. Treatments

a. Surgery: ☐ No ☐ Yes; If yes, Date of Surgery: _____

Type: _____

More surgery planned: _____

Recovery time: _____

b. Medications: ☐ No ☐ Yes

c. Bracing: ☐ No ☐ Yes, please circle one: Daily Use Only for competition

d. Prosthesis: ☐ No ☐ Yes, please circle one: Daily Use Only for competition

e. Wheelchair: ☐ No ☐ Yes

V. Additional Comments:

_____

_____

_____

Doctor Signature:_____Date:_____

Phone number:_____

****ATTENTION: Please have the M.D. initial or sign this form, even if a P.A. fills it out. Thank you.***