



Fédération Internationale de Motocyclisme  
11, route Suisse - CH-1295 Mies (Suisse)  
E-mail: [cmi@fim.ch](mailto:cmi@fim.ch)

## **CIRCUIT CMO QUESTIONNAIRE SPEEDWAY**

**(Form only to be used by CMO)**

This questionnaire has to be completed by the CMO  
(in accordance with art. 09.4.1 of the FIM Medical code)  
and returned to the FIM by e-mail, **TWO months prior** to the event with the following  
attachments:

- 1) A map of the track including medical overview of medical personal, ambulances and fire service
- 2) A map of the track indicating the routes for urgent evacuation
- 3) Written confirmation of CMO about availability of medical staff during the event
- 4) Written confirmation of all hospitals involved
- 5) Road map to hospital(s)

A copy of this form has to be handed over before the first inspection  
to the FIM Medical Representative

**Discipline**  **IMN No.**

**Circuit**  **Date**

**Country**

**CHIEF MEDICAL OFFICER**

**LIC.-No.**

6) **Are all medical services under the control of the Chief Medical Officer** YES  NO

7) **Total personnel during event**

|     |   |   |
|-----|---|---|
| day | 1 | 2 |
|-----|---|---|

|                         |
|-------------------------|
| Doctor (including CMO)  |
| Nurses                  |
| Paramedic or equivalent |
| Other Medical personnel |
| Driver                  |
| Total                   |

|        |  |  |
|--------|--|--|
| number |  |  |
|        |  |  |
|        |  |  |
|        |  |  |
|        |  |  |
|        |  |  |

8) **Vehicles Type B1** Number    
**Vehicles Type B2** Number

Do positions conform to map of sections?  
 Doctor as per Medical Code  YES  NO  
 Personnel as per Medical Code

8a) **Medical Equipment**

|   |                          |                          |
|---|--------------------------|--------------------------|
| Stretcher                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Oxygen supply                           | <input type="checkbox"/> | <input type="checkbox"/> |
| Equipment to immobilise limbs and spine | <input type="checkbox"/> | <input type="checkbox"/> |
| First Aid medicaments and materials     | <input type="checkbox"/> | <input type="checkbox"/> |

8b) **Technical Equipment**

|  |                          |                          |
|--|--------------------------|--------------------------|
| Radio communication with the Race Director and CMO (if applicable) | <input type="checkbox"/> | <input type="checkbox"/> |
| Visible and audible signals  | <input type="checkbox"/> | <input type="checkbox"/> |

8c) **Medical Ground Post** Number

Do positions conform to map of section?  YES  NO

8d) **Personnel**

|  |                          |                          |
|--|--------------------------|--------------------------|
| Doctor, nurse, paramedic or equivalent experienced in emergency care | <input type="checkbox"/> | <input type="checkbox"/> |
| Stretcher bearer   | <input type="checkbox"/> | <input type="checkbox"/> |

8e) **Medical Equipment**

|  |                          |                          |
|--|--------------------------|--------------------------|
| Equipment for initiating resuscitation and emergency treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Cervical collar  | <input type="checkbox"/> | <input type="checkbox"/> |
| Scoop stretcher  | <input type="checkbox"/> | <input type="checkbox"/> |

8f) **Technical Equipment**

|  |                          |                          |
|--|--------------------------|--------------------------|
| Radio communication with Race Director (if applicable) and CMO | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

9) **Is a facility available for treatment of injured competitors**    
 Room, container or tent (please describe/specify) -  
 to complete if there is no Medical Centre

10) **Vehicles for transport to hospital** **Type C** **Number**

11) **Clothing of medical personnel as per Medical Code**

|                          | YES                      | NON                      |
|--------------------------|--------------------------|--------------------------|
| Doctor                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Paramedics or equivalent | <input type="checkbox"/> | <input type="checkbox"/> |

12) **Anti-doping facilities**

13) **Hospitals**

| Type of hospital      | Name of Hospital                          | Time to hospital     |                      | Distance                                  |
|-----------------------|---|----------------------|----------------------|---|
|                       |   | Route                | Air                  | km  |
|                       |   | min                  | min                  |   |
| a) Local hospital     | <input style="width: 100%;" type="text"/> | <input type="text"/> | <input type="text"/> | <input style="width: 100%;" type="text"/> |
| b) General Surgery    | <input style="width: 100%;" type="text"/> | <input type="text"/> | <input type="text"/> | <input style="width: 100%;" type="text"/> |
| c) Orthopaedic/Trauma | <input style="width: 100%;" type="text"/> | <input type="text"/> | <input type="text"/> | <input style="width: 100%;" type="text"/> |

14) **The CIRCUIT CMO QUESTIONNAIRE has been completed by the CMO, medical service is in accordance with art. 09.7.6 of the Medical Code.**

**Remarks:**

**Date:**

**CMO Signature:**