



NEW COMPETITION LICENSE APPLICATION

****FOR DRIVERS WHO ARE ALREADY LICENSED & HAVE COMPLETED AN SVRA EVENT****

All applicants must be at least 18 years old

Name _____ email _____

Address _____ City _____ State _____ Zip _____

Phone(Day) _____ Cell/Evening _____ Fax _____ D/O/B _____

TYPE OF LICENSE APPLYING FOR:

SVRA Competition License \$200

SVRA Super License ** \$250

****Note:** A Super License is required in order to compete in GTP, WSC, Can-Am, F1, F3000, Indy, Indy Lights, IMSA GTO, Tube-frame Trans Am, FIA Group 4.

New Applicants must supply the following. Please use the License Checklist found under FORMS on SVRA website.

- Copy of Current Competition License** with a VMC member organization (i.e. VSCDA, HMSA, VRG, etc) **OR**
- Copy of Current Competition License** with a recognized professional racing organization (i.e. FIA, ALMS, SCCA, etc,) **OR**
- Current Medical Form (IF NOT NOTED ON LICENSE)**
- Digital Photo** of applicant in jpeg format. Please send to SVRA Registrar (Kathy@SVRA.com)

Please complete

Current Licenses Held (include copy) _____

Type of Race Car you intend to race with SVRA: Make _____ Model _____ Year _____

FEES: Expiration date of all licenses is December 31st of the year of issue. SVRA Membership is included with your License Fee.

Credit Card Information

VISA/MC/AMEX/DISCOVER _____

Exp Date ____/____ Verification Code _____

Billing Address _____ City _____ State _____ Zip _____

TOTAL \$ _____

Please make checks payable to SVRA. Mail to SVRA, 1598 Hart Court, Suite 100, Southlake TX 76092

Phone (817)521-5158 Fax(817)953-3550 email: Kathy@svra.com Website: www.svra.com

I understand that SVRA reserves the right to refuse any application for any reason and that acceptance of this License Application and fee by any SVRA official does not constitute approval of the application and that all applications must be officially approved by SVRA.

FOR OFFICIAL USE ONLY

Date Rec'd _____ Amt. Rec'd _____ Cash/CK/CC _____ Photo Rec'd _____

Notarized Waiver Rec'd _____ Medical Form Rec'd or Date _____