STUDENT

Please print legibly.

Name _____ (First / Initial / Last) Birth Date _____ Age _____

Mailing Address _____

_____

City _____ State/Province _____

Country _____ Zip/Postal Code _____

Home Phone (____) _____ Business Phone (____) _____

Telex _____ FAX _____

Name and address of your family or primary care physician

Physician _____ Clinic/Hospital _____

Address _____ Phone (____) _____

Date of last physical examination _____

Name of examiner _____ Clinic/Hospital _____

Address _____ Phone (____) _____

Were you ever required to have a physical for diving? ☐ Yes ☐ No If so, when? _____

PHYSICIAN

This person is an applicant for training or is presently certified to engage in scuba (self contained underwater breathing apparatus) diving. *Your opinion of the applicant's medical fitness for scuba diving is requested. Please review* Guidelines for Recreational Scuba Diver's Physical Examination.

Physician's Impression

☐ I find no medical conditions that I consider incompatible with diving.

☐ I am unable to recommend this individual for diving.

Remarks _____

I have reviewed Guidelines for Recreational Scuba Diver's Physical Examination.

_____, M.D. Date_____
(Physician's Signature)

Physician _____ Clinic/Hospital _____

Address _____

Phone (____) _____