

STUDENT

Please print legibly.

Full Name _____ Birth Date _____ Age _____

Mailing Address _____

City _____ State/Province _____

Country _____ Zip/Postal Code _____

Home Phone () _____ Business Phone () _____

Fax () _____ Cell Phone () _____

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.

Physician's Signature _____, M.D. _____ Date _____

Physician _____ Clinic/Hospital _____

Address _____

Phone () _____