

## STUDENT

Please print legibly.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
First Initial Last

Mailing Address \_\_\_\_\_  
 \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_

Country \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

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

(day/month/year)

Physician \_\_\_\_\_ Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_