STUDENT

Please print legibly.

Name _____ Birth Date _____ Age _____
First Initial Last Day/Month/Year

Mailing Address _____

City _____ State/Province/Region _____

Country _____ Zip/Postal Code _____

Home Phone ( ) _____ Business Phone ( ) _____

Email _____ FAX _____

Name and address of your family physician

Physician _____ Clinic/Hospital _____

Address _____

Date of last physical examination _____

Name of examiner _____ Clinic/Hospital _____

Address _____

Phone ( ) _____ Email _____

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

PHYSICIAN

This person applying for training or is presently certified to engage in skin diving. Your opinion of the applicant's medical fitness for skin diving is requested. There are guidelines attached for your information and reference.

Physician's Impression

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

☐ I am unable to recommend this individual for diving.

Remarks _____

_____

_____

_____ Date _____
Physician's Signature or Legal Representative of Medical Practitioner Day/Month/Year

Physician _____ Clinic/Hospital _____

Address _____

Phone ( ) _____ Email _____