STUDENT

Please print legibly

Name:_____ Birth Date:_____ Age:_____
First Initial Last

Mailing Address:_____

_____

City:_____ State/ Province:_____

Country:_____ Zip / Postal Code:_____

Phone: (_____)_____ Fax: (_____)_____

Name and address of your family or primary care physician

Physician:_____ Clinic/ Hospital:_____

Address:_____
City State Zip

Phone: (____)_____ Date of last physical examination: ____ /____/____
mm / dd / yy

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.

Physician's impression:

____ I find no medical conditions that I consider incompatible with diving.
____ I am unable to recommend this individual for diving.

Remarks: _____

_____

Physician:_____ Clinic/ Hospital:_____

Address:_____
City State Zip

Phone: (_____)_____ Fax: (_____)_____

Physician's Signature:_____ **Date** _____/_____/_____
mm / dd / yy

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