



## **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 scuba (self-contained underwater breathing apparatus) and/or rebreather 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_

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

Physician name and signature \_\_\_\_\_

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

Address \_\_\_\_\_

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

Email \_\_\_\_\_

Stamp hospital or physician