ACCESS AMERICAN
CASUALTY COMPANY

PHYSICIAN'S REPORT

Name Of Driver For Whom This Report Is Being Completed:

Name Of Policyholder/Applicant If Different From Above:

Policy # Or Policy Effective Date:	**Producer Name:**	**Producer #:**

Are there any restrictions currently appearing on your drivers license? □ Yes □ No If yes, explain:

Authorization To Release Medical Information

This authorization permits you (the attending physician and optometrist) to furnish all information you may have regarding my condition while under your observation or treatment. This includes any history obtained, x-ray and physical findings, diagnosis, and prognosis. You are authorized to provide this information to be used for the underwriting of automobile liability insurance. ***Note: The policyholder/applicant, not this insurance company, must pay any fees required for completion of this form.***

Signature of Driver
For Whom This Report
Is Being Completed _____ Date _____

To Be Completed By Physician and Optometrist:

1. **Nature Of Impairment Or Illness**

2. **Duration Of Impairment Or Illness**

3. **Medication (Type(s) and Amount)**

4. **In your opinion, will the impairment, illness or prescribed medication adversely affect the ability of the Driver listed above to safely operate a motor vehicle?**
   □Yes □ No If Yes, please explain

5. **Please Check Off The Appropriate Box That Reflects Your Patients Vision**

Right Eye	**Left Eye**
□ 20/20 □ 20/30 □ 20/40	**□ 20/20 □ 20/30 □ 20/40**

Physician's Name (Please Print)_____ Physician's Signature _____

Optometrist Name (Please Print)_____Optometrist Signature_____

Date _____