PHYSICIAN STATEMENT

NAME _____ POLICY NUMBER _____

TO BE COMPLETED BY PHYSICIAN

1. Date of birth___/___/____

2. Height _____

3. Weight _____

4. What is the corrected vision?_____

5. Describe any hearing impairment: _____

   If yes, how is it being treated? _____

6. Does this person have high blood pressure? _____

   If yes, how is it being treated? _____

7. Does this person have a heart condition? _____

   If yes, please indicate: a) date(s) of attack(s)_____
   b) how is it being treated? _____

8. Has this person had any strokes? _____
   If yes, please indicate: date(s) _____

9. Any Diabeties? _____ a) If yes How long? _____
   b) How is it controlled? (diet, type and amount of medication)?_____
   c) Has this person experienced a diabetic "shock" or "coma"?
   If yes, please indicate date(s)_____

10. Has this person had any blackouts, fainting periods or convulsions in the past 5 years? _____.
    If yes, please indicate date(s) _____
    please describe_____
    _____
    _____

11. Does this person have any physical impairments which might affect his/her ability to drive an automobile?_____ if yes, please explain _____
_____
_____

12. What prescription medicine is being taken?
Please provide the following information
Name of Medicine:_____
Strength of medicine:_____ (mg)
What is the dosage amount of medicine:_____ *(daily,weekly,monthly)*
If so how many years has this person been taking this medicine? _____ Yrs.

13. As his/her physician have you limited driving in any way?_____
If yes, Please explain _____
_____
_____

14. Date of last examination _____

_____ _____
Physician's Signature Date

( ) _____
Office Phone #