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 #