

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 #