



MEDICAL EXAMINER'S REPORT

Examiner's Full name Date of Birth

All the following sections are to be completed by the Medical Examiner on the examination of the proposed Insured Person. Please answer the following questions and give details and dates where appropriate.

1. Has the proposed Insured suffered discomfort, injury or required treatment to any of the following:
 - a. Head (concussion or unconscious) **YES / NO**
 Comments.....
 - b. Neck (cervical spine) **YES / NO**
 Comments.....
 - c. Shoulders **YES / NO**
 Comments.....
 - d. Chest (including Ribs) **YES / NO**
 Comments.....
 - e. Back or Spinal Column (including Coccyx and Tail Bone) **YES / NO**
 Comments.....
 - f. Hips/Pelvis (including Groin, specify side) **YES / NO**
 Comments.....
 - g. Abdomen (including Stomach) **YES / NO**
 Comments.....
 - h. Arms (including Elbows) **YES / NO**
 Comments.....
 - i. Hands (including Wrists, Fingers and Thumbs) **YES / NO**
 Comments.....
 - j. Thighs (including Hamstrings) **YES / NO**
 Comments.....
 - k. Knees **YES / NO**
 Comments.....
 - l. Lower Leg (including Ankle and Achilles Tendons) **YES / NO**
 Comments.....

2. Weight Height
Blood Pressure Pulse Waist

3. Please check the following:

a. Head, Eyes, Ears, Nose, Throat **NORMAL / ABNORMAL**

Comments.....

b. Skin **NORMAL / ABNORMAL**

Comments.....

c. Lungs **NORMAL / ABNORMAL**

Comments.....

d. Heart **NORMAL / ABNORMAL**

Comments.....

e. ECG **NORMAL / ABNORMAL**

Comments.....

f. Abdomen **NORMAL / ABNORMAL**

Comments.....

g. Genitalia **NORMAL / ABNORMAL**

Comments.....

4. On completion of Physical Examination, what is your impression of the Insured Person's ability to continue his/her occupation?

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Medical Examiner (Name – PLEASE USE BLOCK LETTERS)

I certify that I made this examination on the day of

Medical Examiner's Signature

Examiner's Address

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