

# INVICTA DIVERS

## Medical Opinion

### PATIENT SECTION

Please use block capitals

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
First Initial Last Day/Month/Year

Address \_\_\_\_\_

Town/City \_\_\_\_\_ County \_\_\_\_\_

Country \_\_\_\_\_ Post Code \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

Email \_\_\_\_\_

Name and address of your physician (GP or Specialist)

Physician \_\_\_\_\_ Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Name of examiner \_\_\_\_\_ Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Have you ever had a physical examination for SCUBA diving? Yes No

If so, when? \_\_\_\_\_

### PHYSICIAN SECTION

Your patient is applying for training or is presently certified to engage in SCUBA (Self-Contained Underwater Breathing Apparatus) Diving. Your opinion of the applicant's medical fitness for SCUBA diving is requested.

Your patient is not asking you to conduct a medical examination, but for your advice in engaging in a lifestyle which may contraindicate absolutely, relatively, or not at all, for a pre-existing medical condition.

Please tick the appropriate box and comment on any sensible limitations in the remarks section. Thank you.

Physician's Impression:

I find no medical conditions that are incompatible with SCUBA diving.

This individual should refrain from SCUBA diving for medical reasons.

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

STAMP

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_  
Day/Month/Year

Physician \_\_\_\_\_ Clinic/Hospital \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_