| Diver Medical | Physician's Evaluation Form

1. Participant Information
Participant Name : _____
Birthdate: (dd/mm/yyyy) _____
Date: (dd/mm/yyyy) _____

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

2. Evaluation Result
(Please check one box)
Approved - I find no conditions that I consider incompatible with recreational scuba diving or freediving.
Not approved - I find conditions that I consider incompatible with recreational scuba diving or freediving.

3. Physician Information
Physician's Signature: _____
Physician's Name : _____
Specialty: _____
Clinic/Hospital: _____
Address: _____
Phone: _____
Email: _____
Date: (dd/mm/yyyy) _____