

Medical Certificate

Please print legibly

Birthdate ____-____-____ Age ____

Name: _____

Address: _____

City: _____

Country: _____

Home Phone: _____

Home GSM: _____

Business Phone: _____

Fax: _____

Physician

This person is an applicant for training or is presently certified to engage in scuba diving. Your opinion of the applicant's medical fitness for scuba diving is requested.

Physicians impression

I find no medical conditions that I consider incompatible for diving

I am unable to recommend this individual for diving

M.D. Date ____-____-____

Physician: _____

Address: _____

Phone: _____