MEDICAL EVALUATION OF FITNESS FOR SCUBA DIVING REPORT

University of Florida
Division of Environmental Health and Safety
Diving Science and Safety Program

Diver's Name (Print or Type) ______________________ SS# ______________

Date of Birth ______________________ Blood Type ______________

TO THE EXAMINING PHYSICIAN:
The abovementioned person requires a scuba diving medical examination to assess his/her fitness for certification as a Scientific Diver/Diver in Training for the University of Florida. His/her answers on the Medical History form may indicate potential health or safety risks as noted. Your opinion on the applicant's medical fitness is requested. Scuba diving puts unusual stress on the individual in several ways. Please proceed in accordance with the University of Florida Diver Medical Standards (DSSP Dive Safety Manual, section 6) and complete the physician's statement on this form. If you have any questions about diving medicine, please consult with the Divers Alert Network (919) 684-2948. Forward a copy of this document to the Diving Science & Safety Program, PO Box 112205. Send the original and copies of all test results to: Student Infirmary, PO Box 117500, University of Florida , Gainesville, FL 32611-7500.

- Diver **IS** medically qualified to dive for (per section 6.15):
  _____ 2 years (over age 60) _____ 3 years (40 to 60) _____ 5 years (under age 40)

- Diver **IS NOT** medically qualified to dive: _____Permanently _____ Temporarily

REMARKS:

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PHYSICIAN'S STATEMENT:
I have evaluated the abovementioned individual according to the University of Florida's medical standards for scientific diving (DSSP- Diving Safety Manual, Sec. 6) and find no conditions which may be disqualifying. I have discussed with the patient any medical condition(s) which would not disqualify him/her from diving but which may seriously compromise subsequent health. The patient understands the nature of the hazards and the risks involved in diving with these conditions.

My familiarity with applicant is:
O With this exam only
O Regular Physician for _____years
O Other (describe) ________________

My familiarity with diving medicine: O On attached list of physicians O Other (describe)

______________________________M.D. ______________
Signature Date of Exam

______________________________M.D. ______________
Printed or Typed Name Phone

____
Address

APPLICANT'S RELEASE OF MEDICAL INFORMATION FORM

I authorize the release of this information and all medical information subsequently acquired in association with my diving to the Diving Officer and Diving Safety Board or their designee at (place) ______ on (date)_______.

Signature of Applicant______________________________