

**APPENDIX 2**  
**MEDICAL EVALUATION OF FITNESS FOR SCUBA DIVING REPORT**

\_\_\_\_\_  
 Name of Applicant (Print or Type)

\_\_\_\_\_  
 Date(Mo/Day/Year)

To The PHYSICIAN:

This person is an applicant for training or is presently certified to engage in diving with self-contained underwater breathing apparatus (scuba). This is an activity which puts unusual stress on the individual in several ways. Your opinion on the applicant's medical fitness is requested. Scuba diving requires heavy exertion. The diver must be free of cardiovascular and respiratory disease. An absolute requirement is the ability of the lungs, middle ear and sinuses to equalize pressure. Any condition that risks the loss of consciousness should disqualify the applicant.

TESTS: Please initial that the following tests were completed.

**[ ] Initial Examination**

- \_\_\_\_\_ Medical History
- \_\_\_\_\_ Complete Physical Exam, with emphasis on neurological and otological components
- \_\_\_\_\_ Chest X-Ray
- \_\_\_\_\_ Spirometry
- \_\_\_\_\_ Hematocrit or Hemoglobin
- \_\_\_\_\_ Urinalysis
- \_\_\_\_\_ Any further tests deemed necessary by the physician

**Additional testing for first over age 40**

- \_\_\_\_\_ Resting EKG
- \_\_\_\_\_ Assessment of coronary artery disease risk factors including lipid profile and diabetic screening

**Note: Exercise stress testing may be indicated based on risk factor analysis**

RECOMMENDATION:

[ ] APPROVAL. I find no medical condition(s) which I consider incompatible with diving.

[ ] RESTRICTED ACTIVITY APPROVAL. The applicant may dive in certain circumstances as described in REMARKS.

[ ] FURTHER TESTING REQUIRED. I have encountered a potential contraindication to diving. Additional medical tests must be performed before a final assessment can be made. See REMARKS.

[ ] REJECT. This applicant has medical condition(s) which, in my opinion, clearly would constitute unacceptable hazards to health and safety in diving.

REMARKS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have discussed the patient's medical condition(s) which would not seriously interfere with diving but which may seriously compromise subsequent health. The patient understands the nature of the hazards and the risks involved in diving with these defects.

\_\_\_\_\_  
Date Signature M.D.

\_\_\_\_\_  
Name (Print or Type)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

My familiarity with applicant is:

- With this exam only
- Regular Physician for \_\_\_\_\_ years
- Other (describe)\_\_\_\_\_

My familiarity with diving medicine is:

\_\_\_\_\_  
\_\_\_\_\_

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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 Safety Officer and Diving Control Board or their designee at (place) \_\_\_\_\_ on (date)\_\_\_\_\_.

Signature of Applicant \_\_\_\_\_