MEDICAL REPORT

A IDENTIFYING DETAILS

NAME_____ **AGE**_____

ID NO_____ **SEX**_____

TRAINING_____

OCCUPATION_____

B TO BE COMPLETED AND SIGNED BY MEDICAL PRACTIONER

ENCIRCLE APPROPRIATE NUMBER

0 - NORMAL
1 - SLIGHT functional curtailment
2 - MODERATE functional curtailment
3 - SERIOUS functional curtailment
4 - VERY SERIOUS functional curtailment
5 - NO function

B1. ENERGY						
Cardiovascular	0	1	2	3	4	5
Respiratory	0	1	2	3	4	5
Miscellaneous HS/Endocrones/Thyroid/Food – too much, too little	0	1	2	3	4	5
B2. CONTROL						
Motor Control	0	1	2	3	4	5
Sensorial Control	0	1	2	3	4	5
Sight	0	1	2	3	4	5
Hearing	0	1	2	3	4	5
B3. OTHER						
Unusual body dimensions	0	1	2	3	4	5
Ability to transfer	0	1	2	3	4	5

C MEDICAL PRACTIONER'S FINDING

Specify disability_____

_____

Is disability permanent yes/no_____

If not, specify period_____

A special/adapted vehicle is needed/not needed because_____

_____

_____

_____ _____

SIGNATURE **DATE**

_____ _____

CAPACTIY **TELEPHONE NUMBER**

ADDRESS: _____

_____

_____