

MEDICAL REPORT

A IDENTIFYING DETAILS

NAME _____ **AGE** _____

ID NO _____ **SEX** _____

TRAINING _____

OCCUPATION _____

B TO BE COMPLETED AND SIGNED BY MEDICAL PRACTITIONER

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/Endocrines/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 PRACTITIONER'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: _____

