

# UK Sport Diver Medical Certificate of Fitness to Dive

## INSTRUCTIONS TO THE APPLICANT ON THE USE OF THIS FORM

This side of the form is intended to be completed by the Medical Referee if you have answered "YES" to any of the questions in Section A.

Your Certificate of Fitness will be completed and given to you if you are considered fit to dive. You should then show it to your Training or Diving officer and then keep it in your diver training and qualification record book.

Valid for five years to age of 40, 3 years from 40 to 50, and 1 year thereafter although may be restricted by examining doctor to a shorter period of validity

*This is to certify that*

Age.....Membership No.....

*is in my opinion fit to dive at the time of examination. Any changes in medical health must be declared.*

Date.....Valid until.....

Signature of Doctor .....

Address.....  
(or stamp)

Telephone No .....

## SECTION B - To be completed by the Medical Referee who should retain a copy for record purposes

Height    metres

Weight    kg

		<b>NORMAL?</b>	
		<b>YES</b>	<b>NO</b>
Ears:	R. Drum	<input type="checkbox"/>	<input type="checkbox"/>
	Canal	<input type="checkbox"/>	<input type="checkbox"/>
	L. Drum	<input type="checkbox"/>	<input type="checkbox"/>
	Canal	<input type="checkbox"/>	<input type="checkbox"/>
Sinuses, nose, throat		<input type="checkbox"/>	<input type="checkbox"/>
Chest		<input type="checkbox"/>	<input type="checkbox"/>
Peak Flow	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVS		<input type="checkbox"/>	<input type="checkbox"/>
BP	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen		<input type="checkbox"/>	<input type="checkbox"/>
CNS		<input type="checkbox"/>	<input type="checkbox"/>
Joints and Limbs		<input type="checkbox"/>	<input type="checkbox"/>
Personality or Mental Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Urine: Free from albumen		<input type="checkbox"/>	<input type="checkbox"/>
Free from sugar		<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray (only if indicated)		<input type="checkbox"/>	<input type="checkbox"/>

Please comment below on any abnormalities

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Date of Chest X-ray .....  
(if indicated)

Place .....

Fit                       Unfit

Signature of Doctor.....Date.....

Address .....  
(or stamp)

Telephone No .....