

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

		NORMAL?	
		YES	NO
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