

DIVE MEDICAL EXAMINATION FORM

PRINTED Name of Licensed Physician: _____

**PRINTED Address of Facility where
Medical examination was performed:** _____

Phone number of examining physician: _____
(include area code)

I, _____, have examined _____
(Printed name of physician) (Printed name of dive team member)

on this date _____, and have determined that
(Printed date of examination)

he/she is **FIT AND APPROVED TO DIVE.**

Signature of examining physician: _____

Printed name of examining physician: _____