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**

_____ _____

CAPACITY **TELEPHONE NUMBER**

ADDRESS: _____

_____

_____