

Diver Medical | Physician's Evaluation Form

Participant Name _____
(Print)

Birthdate _____
Date (dd/mm/yyyy)

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

Evaluation Result

- Approved – I find no conditions that I consider incompatible with recreational scuba diving, or freediving.
- Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

Physician's Signature

Date (dd/mm/yyyy)

Physician's Name (Print) _____

Specialty _____

Clinic/Hospital _____

Address _____

Phone _____ Email _____

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:
The Undersea & Hyperbaric Medical Society
DAN (US)
DAN Europe
Hyperbaric Medicine Division, University of California, San Diego