

# Diver Medical | Physician's Evaluation Form

Participant Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
(Print) 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](http://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 \_\_\_\_\_ Specialty \_\_\_\_\_  
(Print)

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