MEDICAL STATEMENT
COMMERCIAL VEHICLE OR GARAGE LIABILITY

INSURED:	PRODUCER

Policy No.	Eff. Date:	Exp. Date:	Company

Driver's Name and Address:

Date of Birth:	Age:	Sex:	Occupation:

Name and Address of Physician Making This Report:	Years Under Phys. Care	Date of Last Visit

MEDICAL HISTORY

EXPLAIN ALL "YES" ANSWERS IN REMARKS. PLEASE INCLUDE QUESTION NUMBER AND EXPLANATION.

EYESIGHT	YES	NO
1. Have you lost the use or sight of either eye?	☐	☐
2. Is Peripheral (side) vision restricted?	☐	☐
3. Are you color blind?	☐	☐
4. Do you have or have you ever had cataracts?	☐	☐
5. Are sight deficiencies corrected by glasses or contacts?	☐	☐
6. Date of Last Examination:		
HEARING		
7. Are you unable to hear normal conversations?	☐	☐
8. Is hearing aid used?	☐	☐
HEART		
9. Have you ever been treated for heart disease?	☐	☐
10. Have you ever had a heart attack?	☐	☐
11. Do you have a pacemaker?	☐	☐
12. Medication and dosage used.		
13. When was last treatment or check-up?		
LIMBS		
14. Have you lost an arm or a leg?	☐	☐
15. Have you lost the use of an arm or a leg?	☐	☐
16. Does car have special controls?	☐	☐
DIABETES		
17. Have you ever been tested for diabetes?	☐	☐
a) Latest Blood Sugar Test Date:		
b) Medication and Dosage Used:		
c. Method of Administration:		

EPILEPSY	YES	NO
18. Have you ever been treated for epilepsy?	☐	☐
a) If yes, kind and date of last seizure:		
b) Medication and dosage used:		
BLOOD PRESSURE		
19. Have you ever been treated for high blood pressure?	☐	☐
a) If yes, date of last treatment:		
b) Last reading:		
c) Medication and dosage used:		
MISCELLANEOUS		
20. Have you ever been treated or received medication for any neurological, mental or emotional problem?	☐	☐
21. Have you every been treated or received medication for any neuromuscular disease (muscular dystrophy, multiple sclerosis, cerebral palsy, etc.)?	☐	☐
22. Are there any restrictions posted on your driver's license other than glasses?	☐	☐
23. Indicate date of last treatment, if applicable.		
a) Convulsions:		
b) Fainting Spells:		
c) Loss of Equilibrium:		
d) Alcohol or Drug Abuse:		
e) Mental or Emotional Illness:		
f) Complete Physical Examination:		
24. Are you under the care of a physical for any condition not mentioned above?	☐	☐

REMARKS:

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL OF THE FOREGOING STATEMENTS ARE TRUE.

PHYSICIAN'S SIGNATURE ______________________ DATE ______________