THE INSURANCE COMPANY OF THE WEST INDIES (CAYMAN) LIMITED

150 Smith Road, P.O. Box 461 GT, George Town, Grand Cayman

Tel: (345) 949-6970, Email: cayman@icwi.com

Name: ______________________ Age: __________ Date of Birth: ____________________

Address: ____

History of:

Angina/Recent Myocardial Infarction/Heart problems	Yes	No	Giddiness/Fainting spells	Yes	No
Diabetes Mellitus (Insulin/Non-Insulin Dependent)	Yes	No	Epilepsy	Yes	No
Hypertension	Yes	No	Hallucinations	Yes	No

Cerebrovascular Accident or TIAs ____

Drugs (if yes, please list below) Yes No

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Decreased Mental Function ____

Examination

- Pulse / Rate Regularity ____________________________
- Blood Pressure: ____________________________
- Vision - without glasses ____________________________
  - with glasses ____________________________
- Visual fields ____________________________
- Hearing ____________________________
- Assessment of neck mobility ____________________________
- Locomotion disability ____________________________
- Mental state ____________________________
- Reaction time ____________________________
- Vision * ____________________________

* *Please note:*
- *Visual acuity of at least 6/10 [ability to read 3½" (9 cm) letters at a 25 yards (23 m)] is required to drive*
- *Adequate field of vision (more than 120 degrees) is essential to drive*
- *Monocular vision does not disqualify a person from driving provided that the field of vision in the runaway eye is fine*

Please comment on any unfavourable features discovered upon examination or in the applicant's history that you consider of importance in assessing the risk: ____

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Do you consider the applicant fit to drive? (If no, please explain): ______________________________

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I certify that I have made a thorough physical examination of the applicant, and the answers given are a true record of the examination.

____________________________	____________________________
Medical Doctor's Signature	Date
____________________________	____________________________
Medical Doctor's Name	Medical Doctor's Address