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, Fax: (345) 949-6929

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			

_____

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: _____

_____

_____

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

_____

_____

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