



THE INSURANCE COMPANY OF THE WEST INDIES LIMITED

2 St. Lucia Avenue, Kingston 5
Tel: 926-9040-7, 926-9182-91, Fax: 929-6641

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