**THE INSURANCE COMPANY OF THE WEST INDIES LIMITED**
2 St. Lucia Avenue, Kingston 5
Tel: 926-9040-7, Email: direct@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 | | | |

_____

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