



THE INSURANCE COMPANY OF THE WEST INDIES (SINT MAARTEN) B.V.

Welfare Road #40B, Cole Bay, St. Maarten
Tel: (721) 544-5074, Email: stmaarten@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