AssuranceAmerica
Managing General Agency

PHYSICIAN STATEMENT - FITNESS STATEMENT

INSUREDS NAME _____ **POLICY NUMBER** _____

On _____, I examined _____ age _____

to determine his/her mental and physical fitness to operate a motor vehicle. My findings are as follows:

1. General health:

   In your professional opinion, is the insured physically and or mentally capable to operate a motor vehicle?

   _____

   b. Is there any nervous, organic, or functional disease which is advanced, or is likely to advance during the next 12 months, to a degree that will interfere with the insured's driving ability?

   _____

2. Mental health: Is his/her alertness and mental activity adequate to cope with emergencies frequently encountered in driving?

   _____

3. Physical condition:

   a. Has he/she lost any of the following members: fingers, hand, arm, foot, leg ? If so, indicate the member(s):

   _____

   b. Is there any partial or total loss of use of any of the above members that impairs safe driving ability? _____

   c. Is there any other bodily defect or limitation that is likely to hinder safe driving? _____

4. Hearing: Can he/she hear ordinary conversation without a hearing aid? _____

5. Vision:

   a. Has he/she lost the sight of either eye? _____

   b. Is there any opacity of the crystalline lens of either or both eyes?_____

   c. Can he/she distinguish red and green colors? _____

   d. Visual acuity - right eye: _____
      Visual acuity - left eye: _____
      Visual acuity - both eyes:_____

   e. Are the above visual acuity ratings with the natural vision or with corrective glasses? _____

Signature of examining physician _____

Typed or printed name of physician _____

Address _____

Phone number_____