

NECK	<input type="checkbox"/> Yes <input type="checkbox"/> No	Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RIGHT SHOULDER	<input type="checkbox"/> Yes <input type="checkbox"/> No	Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEFT SHOULDER	<input type="checkbox"/> Yes <input type="checkbox"/> No	Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROPOSED INSURED: _____	Date of Birth: ____ / ____ / ____
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CHEST (including ribs) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

UPPER BACK (Thoracic Spine) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LOWER BACK (Lumber Spine incl. Coccyx tail bone) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROPOSED INSURED: _____	Date of Birth: ____ / ____ / ____
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PELVIS/HIPS (incl. groin - specify side) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Details (discomfort, injury or treatment) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Details of any surgery: _____ _____ _____ _____ Current Prognosis: _____ _____ _____ _____ _____ _____

ABDOMEN (incl. stomach) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Details (discomfort, injury or treatment) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Details of any surgery: _____ _____ _____ _____ Current Prognosis: _____ _____ _____ _____ _____ _____

RIGHT ARM (incl. elbow) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Details (discomfort, injury or treatment) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	Details of any surgery: _____ _____ _____ _____ Current Prognosis: _____ _____ _____ _____ _____ _____

PROPOSED INSURED: _____	Date of Birth: / /
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LEFT ARM (incl. elbow) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RIGHT HAND (incl. wrist, fingers & thumb) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEFT HAND (incl. wrist, fingers & thumb) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROPOSED INSURED: _____	Date of Birth: / /
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RIGHT THIGH (incl. hamstring) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEFT THIGH (incl. hamstring) <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RIGHT KNEE <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROPOSED INSURED: _____	Date of Birth: ____ / ____ / ____
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LEFT KNEE <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

RIGHT LOWER LEG incl. ankle & Achilles tendon <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEFT LOWER LEG incl. ankle & Achilles tendon <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROPOSED INSURED: _____	Date of Birth: _____ / _____ / _____
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RIGHT FOOT <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LEFT FOOT <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal Exam Result: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date(s)	Details (discomfort, injury or treatment)	Details of any surgery: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	Current Prognosis: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROPOSED INSURED: _____	Date of Birth: ____ / ____ / ____
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SECTION 3

1. Height: _____ 2. Weight: _____
 3. Blood Pressure: _____ 4. Pulse: _____

5. Please tick the appropriate box:

	Normal	Abnormal	Comments
Head, Eyes, Ears, Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
EKG	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

On completion of physical examination, overall impression with regard to player's ability to continue his career.

As a physician, please state your relationship to the proposed insured, i.e. Personal Physician, Team Physician etc.?

I certify that I made this examination at _____ a.m. p.m.
 on the _____ day of _____, 20____
 Examination made at my office, individual's office, individual's home Other- _____

EXAMINER'S SIGNATURE _____
 Examiner's Address: _____

APPLICANT'S SIGNATURE _____
 APPLICANT'S FULL NAME _____

PROPOSED INSURED: _____ Date of Birth: _____ / _____ / _____

