

## SPORTS APPLICATION FORM AND MEDICAL EXAMINER'S REPORT

### PART 1 - APPLICATION FORM. This section constitutes pages 1 - 4.

The Applicant must answer all questions in ink. Make sure to sign and date the Application.

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#### Section 1: Applicant Information

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Full Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Birth Date \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Sex: Male  Female   
Month Day Year

Sport \_\_\_\_\_ Professional \_\_\_\_\_ Other \_\_\_\_\_

Name of Team \_\_\_\_\_ Position \_\_\_\_\_

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#### Section 2: Health Questionnaire - Circle Yes or No. Please provide additional information and dates in the space below.

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- |   |     |    |
|---|-----|----|
| 1. Are you currently free of injury, illness or discomfort? If No, explain below.   | Yes | No |
| 2. Are you currently physically able to perform all of the duties required in your sport as stated in Section 1 of the Application Form? If No, explain below.          | Yes | No |
| 3. Have you missed any playing time during the last 24 months as a result of injury, illness, discomfort or for any other reason? If Yes, explain below.                | Yes | No |
| 4. Do you require any type of knee brace while playing or practising? If Yes, explain below.  | Yes | No |
| 5. Have you consulted your team physician or any other physician in the last 24 months other than for routine examination or team physical? If Yes, explain below.      | Yes | No |
| 6. Have you within the last 24 months, taken any pain reducing or anti-inflammatory medication? If Yes, explain below, including name of drug, dates taken, and reason. | Yes | No |
| 7. During the last 12 months, have you suffered any injury, sickness or discomfort for which you have not sought medical advice? If Yes, explain below.                 | Yes | No |
| 8. Have you been advised or do you have reason to believe that you may need medical treatment in the future? If Yes, explain below.                                     | Yes | No |
| 9. Have you ever been advised to have treatment which has not been undertaken? If Yes, explain below.   | Yes | No |

Additional Information (please indicate question number for which you are providing details): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Section 3: Circle Yes or No. If Yes, please give details. Additional space is provided below.**

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Do you engage in any of the following activities, or other similar activities, which may be considered hazardous?

- |  |     |    |       |
|--|-----|----|-------|
| 1. Piloting an aircraft                            | Yes | No | _____ |
| 2. Skydiving or hang-gliding                       | Yes | No | _____ |
| 3. Water or underwater sports                      | Yes | No | _____ |
| 4. Winter sports, other than skating or curling    | Yes | No | _____ |
| 5. Motor sports or motorcycling                    | Yes | No | _____ |
| 6. Rock climbing or mountaineering                 | Yes | No | _____ |
| 7. Other activities excluded by your club contract | Yes | No | _____ |

Details: \_\_\_\_\_

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**Section 4: Circle Yes or No. If Yes, please give details. Additional space is provided below.**

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Have you ever injured or suffered pain or discomfort, or had surgery to any of the following? If Yes, give details including dates.

- |  |     |    |       |
|--|-----|----|-------|
| 1. Head  | Yes | No | _____ |
| 2. Neck (Cervical Spine)   | Yes | No | _____ |
| 3. Right Shoulder (including Clavicle and Shoulder Blade)              | Yes | No | _____ |
| 4. Left Shoulder (including Clavicle and Shoulder Blade)               | Yes | No | _____ |
| 5. Chest (including ribs, sternum & diaphragm)                         | Yes | No | _____ |
| 6. Upper Back  | Yes | No | _____ |
| 7. Lower Back (including tail bone)                                    | Yes | No | _____ |
| 8. Right Hip   | Yes | No | _____ |
| 9. Left Hip  | Yes | No | _____ |
| 10. Groin? Specify side.   | Yes | No | _____ |
| 11. Abdominal Muscles  | Yes | No | _____ |
| 12. Right Arm (including elbow)  | Yes | No | _____ |
| 13. Left Arm (including elbow)   | Yes | No | _____ |
| 14. Right Hand (including wrist/fingers)                               | Yes | No | _____ |
| 15. Left Hand (including wrist/fingers)                                | Yes | No | _____ |
| 16. Right Thigh (including hamstring)                                  | Yes | No | _____ |
| 17. Left Thigh (including hamstring)                                   | Yes | No | _____ |
| 18. Right Knee   | Yes | No | _____ |
| 19. Left Knee  | Yes | No | _____ |
| 20. Right Lower Leg (including ankle & Achilles tendon)                | Yes | No | _____ |
| 21. Left Lower Leg (including ankle & Achilles tendon)                 | Yes | No | _____ |
| 22. Right Foot (including toes)  | Yes | No | _____ |
| 23. Left Foot (including toes)   | Yes | No | _____ |
| 24. Have you suffered any other injuries, discomfort or conditions to: |     |    |       |
| a. Bones   | Yes | No | _____ |
| b. Joints  | Yes | No | _____ |
| c. Muscles   | Yes | No | _____ |
| d. Nerves  | Yes | No | _____ |

Additional Information (please indicate question number for which you are providing details): \_\_\_\_\_

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**Section 5: Circle Yes or No. If Yes, please give details including dates. Additional space is provided below.**

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Within the last 10 years, have you ever shown indications of, suffered from, been treated for, or been prescribed treatment for any condition of the following:

1. Cardiac such as heart murmur, heart attack, angina, chest pain, high or low blood pressure, or any other disease of the heart or blood vessels? Yes No \_\_\_\_\_
2. Respiratory system such as asthma, chronic bronchitis, or emphysema, shortness of breath, pneumonia or any other respiratory disease? Yes No \_\_\_\_\_
3. Digestive such as ulcer, colitis, bleeding, gallbladder or liver disease or any other disorder of the stomach, intestines or rectum? Yes No \_\_\_\_\_
4. Nervous system such as paralysis, anxiety, seizures, depression or any other mental disease? Yes No \_\_\_\_\_
5. Endocrine such as diabetes, thyroid, or any other glandular disease? Yes No \_\_\_\_\_
6. Any disease of the blood? Yes No \_\_\_\_\_
7. Skin disease, cancer, cyst or tumor? Yes No \_\_\_\_\_
8. Rheumatism, arthritis, ruptured disc, or any disease injury or deformity of the spine, joints, bones or muscles? Yes No \_\_\_\_\_
9. Any disease of the kidneys, bladder, prostate or reproductive organs? Yes No \_\_\_\_\_
10. Any disease of the eyes, ears, nose or throat? Yes No \_\_\_\_\_
11. Paralysis whether complete or partial, regardless of length of time or duration? Yes No \_\_\_\_\_

Additional Information (please indicate question number for which you are providing details): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Section 6: Concussions**

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1. Number of incidents and dates: \_\_\_\_\_  
\_\_\_\_\_
2. Did you lose consciousness in any of the incidents? \_\_\_\_\_  
\_\_\_\_\_
3. What grade or degree of severity were they? \_\_\_\_\_  
\_\_\_\_\_
4. How much time in total did you miss after each incident? (include number of games missed) \_\_\_\_\_  
\_\_\_\_\_

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**Section 7: Circle Yes or No. If Yes, please give details. Additional space is provided below.**

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1. Are you now, or have you ever been treated for substance or alcohol abuse? Yes No \_\_\_\_\_
2. Have you ever used marijuana, mood-altering drugs, narcotics, cocaine, heroin, barbituates, LSD or amphetamines? Yes No \_\_\_\_\_

**PLEASE READ CAREFULLY**

**IT IS UNDERSTOOD AND AGREED AS FOLLOWS:**

1. I have read the statements and answers recorded herein. They are to the best of my knowledge and belief, true and complete and correctly recorded. The Insurer will rely on this information in making their determinations.
2. No agent, broker or medical examiner has authority to waive the answers to any question, to determine insurability, to waive any of the Insurer’s rights or requirements, or to make or alter any contract or policy.
3. The Insurer has the right to require medical exams and tests to determine insurability.
4. The insurance applied for will not take effect unless the health of the Proposed Insured remains as stated in the Application on the inception date of the proposed policy.

**AUTHORIZATION**

To all physicians, medical professionals, hospitals, clinics, other health care providers, insurers, employers, Medical Information Bureau (MIB), consumer reporting agencies, other insurance support organizations, and other persons who have information about the Proposed Insured:

I authorize you to give the Insurer, its reinsurers, its agents: (a) all information you have as to illness, injury, medical history, diagnosis, treatment, and prognosis with respect to any physical or mental condition of the Proposed Insured; and (b) any non-medical information, including any investigative consumer report, which the company believes it needs to perform the business functions described below.

The information obtained will be used to determine if the Proposed Insured is eligible for (a) the insurance requested; or (b) benefits under a policy which is in force. It will also be used for any other business purpose which relates to the insurance requested or the policy which is in force.

I understand that I may withdraw my consent at any time, in writing, subject to legal or contractual restrictions and reasonable notice.

The form will be valid for 36 months. I know that I may request a copy of it. I agree that a photocopy is as valid as the original.

\_\_\_\_\_  
month    day    year

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Name of Proposed Insured (PLEASE PRINT)

**THE FOLLOWING DECLARATION IS ONLY TO BE COMPLETED WHERE A TEAM IS EFFECTING THIS INSURANCE ON BEHALF OF A PLAYER.**

We hereby warrant that to the best of our understanding and belief, all of the answers and statements herein contained are full, complete and true and have been correctly recorded and we do not know of any other information which is likely to influence the decision of the Insurer and that we are willing to accept a Policy, subject to the terms and conditions of such Policy, to be issued on the basis of and in consideration of the proposal, which we understand shall be attached to and constitute a part of the Contract of Insurance.

\_\_\_\_\_  
Signature of Team Official

\_\_\_\_\_  
month    day    year

\_\_\_\_\_  
Position Held

## PART 2 - MEDICAL EXAMINER'S REPORT

**This section constitutes pages 5 - 9.**

**All questions must be answered in ink.**

**All following sections to be completed by a Medical Examiner on examination of player.**

Name of Proposed Insured: \_\_\_\_\_

Have you examined and/or treated this patient in the past?	Yes, for _____ years No
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**Current Vital Signs on this Examination**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

**Please check the appropriate box**

	Normal	Abnormal
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"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS:


<b>Has the Proposed Insured suffered discomfort, injury or required treatment to any of the following:</b>	<b>Upon examination, were there any abnormalities identified?</b>
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<b>1. HEAD</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality) Concussion details, if applicable.	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS
<b>2. NECK (Cervical Spine)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS
<b>3. RIGHT SHOULDER, CLAVICLE, SCAPULA</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS
<b>4. LEFT SHOULDER, CLAVICLE, SCAPULA</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS
<b>5. CHEST (including Ribs, Sternum, Diaphragm)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS
<b>6. UPPER BACK (Thoracic Spine)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS
<b>7. LOWER BACK</b> (Lumbar spine incl. Coccyx and Sacral Spine) YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS
<b>8. RIGHT HIP</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                                      PROGNOSIS

<b>Has the Proposed Insured suffered discomfort, injury or required treatment to any of the following:</b>	<b>Upon examination, were there any abnormalities identified?</b>
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<b>9. LEFT HIP</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS
<b>10. RIGHT GROIN</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS
<b>11. LEFT GROIN</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS
<b>12. ABDOMINAL MUSCLES</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS
<b>13. RIGHT ARM (including elbow)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS
<b>14. LEFT ARM (including elbow)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS
<b>15. RIGHT HAND (including wrist/fingers)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS
<b>16. LEFT HAND (including wrist/fingers)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY                      CURRENT & FUTURE AND/OR TREATMENT                      PROGNOSIS

<b>Has the Proposed Insured suffered discomfort, injury or required treatment to any of the following:</b>	<b>Upon examination, were there any abnormalities identified?</b>
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<b>17. RIGHT THIGH (including hamstring)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS
<b>18. LEFT THIGH (including hamstring)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS
<b>19. RIGHT KNEE</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS
<b>20. LEFT KNEE</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS
<b>21. RIGHT LOWER LEG (including ankle and achilles tendon)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS
<b>22. LEFT LOWER LEG (including ankle and achilles tendon)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS
<b>23. RIGHT FOOT (including toes)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS
<b>24. LEFT FOOT (including toes)</b> YES NO	
DATES                      DETAILS (discomfort, injury, or abnormality)	DETAILS OF ANY SURGERY AND/OR TREATMENT                      CURRENT & FUTURE PROGNOSIS

On completion of physical examination, please provide your overall impression with regard to player's ability to continue his career:

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As a physician, please state your relationship to the Proposed Insured, i.e. Personal Physician, Team Physician, etc.

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I certify that I made this examination on \_\_\_\_\_  
month            day            year

EXAMINER'S SIGNATURE

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EXAMINER'S NAME (please print)

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EXAMINER'S ADDRESS

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TELEPHONE NUMBER \_\_\_\_\_

FAX NUMBER \_\_\_\_\_

E-Mail \_\_\_\_\_

ANY ADDITIONAL COMMENTS:

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