

Part II MEDICAL EXAMINER'S REPORT

INSTRUCTION: In performing the examination, bear in mind history in Part I submitted in connection with Reinstatement

1. a. Name and address of Member _____ (If none, so state) b. Date and reason last consulted _____ c. What treatment was given or medication prescribed? _____										
2.	HEIGHT meter Ft. In.	WEIGHT kilos lbs.	CHEST (full inspiration) in.	CHEST (forced expiration) in.	ABDOMEN at Umbilicus in.	<b>If yes, please give details:</b>				
Did you weigh and measure Member? <input type="checkbox"/> Yes <input type="checkbox"/> No										
3. BLOOD PRESSURE (if above 140 systolic or 90 diastolic, report additional readings at 5-minute interval)										
Systolic		1st	2nd	3rd	<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%;"></td> <td style="width: 33%;"></td> </tr> </table>					
Diastolic (Disappearance of sound)										
4. PULSE (If irregular or rate is over 90 or less than 60 per minute, perform EXERCISE TEST*)										
		At rest	After Exercise	3 Minutes Later						
Rate per minute										
Irregularities per minute										
* Ten full kneebends from standing position in one minute.										
5. HEART is there any										
a. Enlargement? _____		c. Arrhythmis? _____								
b. Murmur? _____		d. Dsynea? _____								
( Give details and your impression at space provided).										
6. Is there, on examination, any abnormality of the following: (please encircle applicable items and give details)										
		YES	NO							
a. Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)		<input type="checkbox"/>	<input type="checkbox"/>							
b. Skin (incl. scars), lymphnodes, varicose veins or peripheral arteries?		<input type="checkbox"/>	<input type="checkbox"/>							
c. Nervous System (include reflexes, gait, paralysis?)		<input type="checkbox"/>	<input type="checkbox"/>							
d. Respiratory System?		<input type="checkbox"/>	<input type="checkbox"/>							
e. Abdomen (include scars)?		<input type="checkbox"/>	<input type="checkbox"/>							
f. Endocrine System (include thyroid and breasts)?		<input type="checkbox"/>	<input type="checkbox"/>							
g. Musculoskeletal System (include spine, joints, amputations, deformities)?		<input type="checkbox"/>	<input type="checkbox"/>							
7. Is appearance unhealthy or older than age stated?		<input type="checkbox"/>	<input type="checkbox"/>							
8. Are you aware of additional information about the health habits that may affect the risk adversely? ( A CONFIDENTIAL REPORT MAY BE SENT TO THE MEMBERSHIP DIVISION PPSTA)		<input type="checkbox"/>	<input type="checkbox"/>							
9. Are you related to the Member?		<input type="checkbox"/>	<input type="checkbox"/>							
10. How long have you known the Member?										

I certify that I have carefully examined the person named above and that the examination was made at \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ o'clock AM/PM. I have asked each question exactly as set forth in Part I and that the Member's answers thereto are in my handwriting and are exactly as stated by the Member to me and that the Member signed the declarations at the foot of Part I in my presence

\_\_\_\_\_  
Signature of Examiner

\_\_\_\_\_  
Examiner's Name in Print

\_\_\_\_\_  
PTR License No.

\_\_\_\_\_

**INSTRUCTION TO THE MEDICAL EXAMINER**

1. When an examination has begun, the report thereof becomes the property of PPSTA and must not be suppressed nor destroyed regardless of your recommendation in order to avoid declination.
2. Your report should give the PPSTA a clear picture of the person examined.
3. An examiner is not allowed to examine his relatives.
4. Any erasures or alterations in the statement made by the Member must be initialed by him. Any erasures or alterations in your report should be, initialed by you.
5. Please review both sides of the form mailing to see that every applicable question is fully and correctly answered.