DIVING MEDICAL EXAMINATION

CONSENT FORM

I, ____________________________________
(Printed name of student)

Authorize my examining physician:

Dr. ____________________________________

Address: ______________________________
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and any physician, hospital, or clinic to furnish any information of my medical record, so as to determine my medical fitness to dive, to:

The Medical Physician & Consultant for Diving & Hyperbaric Medicine
Minnesota Commercial Diver Training Center
712 Washington Street
Brainerd, MN 56401

______________________________	______________________________
(Printed Name)	(Printed Name of Witness)
______________________________	______________________________
(Signature)	(Witness' Signature)
______________________________	______________________________
(Date)	(Date)