



PROFESSIONAL ATHLETES APPLICATION

MEDICAL DOCTOR'S REPORT FORM

Send completed application and exam to:

PETERSEN INTERNATIONAL UNDERWRITERS

23929 Valencia Boulevard Suite 215, Valencia, CA 91355

Email: piu@piu.org • Fax: (661) 254-0604 • Telephone (800) 345-8816

ALL following sections are to be completed by Doctor on examination of player

Proposed Insured: First _____ Middle _____ Last _____
Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____
Sport: _____ Team Name: _____ Position: _____

1. Have you examined and/or treated this patient in the past?: Yes For _____ Years No
2. Has the Proposed Insured suffered discomfort, injury or treatment of any kind to any of the following? Doctor to query Proposed Insured. If answered "Yes" to any of the questions, please give details including dates (day/month/year).

- | | | |
|--|--|-------|
| a. Head? (Including Concussion Or Unconsciousness) | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| b. Neck Or Cervical Spine? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| c. Right Shoulder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| d. Left Shoulder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| e. Chest (Including Ribs)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| f. Upper Back (Thoracic Spine)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| g. Lower Back (Lumbar Spine Including Coccyx And Tail Bone)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| h. Pelvis/Hips (Including Groin - Specify Side)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| i. Abdomen (Including Stomach)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| j. Right Arm (Including Elbow)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| k. Left Arm (Including Elbow)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| l. Right Hand (Including Wrist & Digits)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| m. Left Hand (Including Wrist & Digits)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| n. Right Thigh (Including Hamstring)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| o. Left Thigh (Including Hamstring)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| p. Right Knee? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| q. Left Knee? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| r. Right Lower Leg (Including Ankle And Achilles Tendon)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| s. Left Lower Leg (Including Ankle And Achilles Tendon)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| t. Right Foot? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| u. Left Foot? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |



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Proposed Insured: _____

If there is not sufficient space, please attach your answers on a separate sheet.

3. Doctor to examine Proposed Insured. If exam results were not normal, please describe in detail.

Exam Results

Normal Abnormal

- | | | | |
|--|--------------------------|--------------------------|-------|
| a. Head? (Including Concussion Or Unconsciousness) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| b. Neck Or Cervical Spine? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| c. Right Shoulder? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| d. Left Shoulder? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| e. Chest (Including Ribs)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| f. Upper Back (Thoracic Spine)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| g. Lower Back (Lumbar Spine Including Coccyx And Tail Bone)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| h. Pelvis/Hips (Including Groin - Specify Side)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| i. Abdomen (Including Stomach)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| j. Right Arm (Including Elbow)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| k. Left Arm (Including Elbow)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| l. Right Hand (Including Wrist & Digits)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| m. Left Hand (Including Wrist & Digits)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| n. Right Thigh (Including Hamstring)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| o. Left Thigh (Including Hamstring)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| p. Right Knee? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| q. Left Knee? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| r. Right Lower Leg (Including Ankle And Achilles Tendon)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| s. Left Lower Leg (Including Ankle And Achilles Tendon)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| t. Right Foot? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| u. Left Foot? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |



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Proposed Insured: _____

If there is not sufficient space, please attach your answers on a separate sheet.

4. Please check the appropriate boxes:

	Normal	Abnormal	
Head	<input type="checkbox"/>	<input type="checkbox"/>	_____
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"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulse	<input type="checkbox"/>	<input type="checkbox"/>	_____

5. Has the Proposed Insured ever lost consciousness? Yes No
If "Yes" please provide details: _____

6. Do you have any knowledge or suspicion of bulged or herniated disc(s) in the back and/or neck? Yes No
If "Yes" please provide details: _____

7. Is the Proposed Insured currently taking medication(s)? Yes No
If "Yes" please provide the medication and the reason being taken: _____

8. On completion of physical examination, please indicate overall impression with regard to player's ability to continue their career.

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

Proposed Insureds Signature _____ Date _____

Physician Information

Physicians Name:	First _____	Middle _____	Last _____
Address:	Number & Street _____		
	City _____	State _____	Zip Code _____
Phone Number:	_____	Fax: _____	Email: _____
Physician's Signature:	_____		Date _____



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(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604
Website: <http://www.piu.org> E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION
This Authorization complies with the HIPAA Privacy Rule

Name of Proposed Insured _____ Date of Birth _____

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriter, or its assigned authorized agents/representative including, but not limited to: Secure Image Solutions, for the purpose of insurance underwriting or claims administration.

For purposes of this authorization, medical records shall include all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, information and/or HIV Tests/Test Results, and any other pertinent medical information.

I understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above. Additionally it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to:

Petersen International Underwriters
23929 Valencia Boulevard, Suite 215
Valencia, California 91355

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization. This Authorization will expire 2 years after the date the Authorization.

Signature of Proposed Insured/Patient

Date

*Signature of Legal Representative (if other than Proposed Insured/Patient)

Date

Printed Name and Relationship

**If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.*