

Place an X next to the activity(ies), environment(s), and equipment for which you have diving experience:

- | | | |
|----------------------|---|-----------------------------|
| _____ Ocean | _____ Surface supplied air | _____ Dry suit |
| _____ Lakes | _____ Surface supplied HeO ₂ | _____ Hot-water suit |
| _____ Rivers | _____ Mixed gas diving | _____ Band mask |
| _____ Altitude | _____ Surface decompression | _____ Full-face mask scuba |
| _____ Strong current | _____ Decompression diving | _____ Twin scuba tanks |
| _____ Cold water | _____ Recompression chamber | _____ U/W still photography |
| _____ Tropical water | _____ Saturation (air) | _____ U/W video photography |
| _____ Ice diving | _____ Enriched Air Nitrox | _____ Helmet diving |
| _____ Wreck diving | _____ 5' or less visibility | _____ Lift bags |
| _____ Cave diving | _____ Jacket-type B.C. | _____ Night diving |

Have you ever completed an oxygen tolerance test? No _____ Yes _____

If Yes, fill in details: Date _____ Purpose _____

Problems or complications _____

PLEASE SEND A COPY OF THE RESULTS.

Have you ever experienced decompression sickness, air embolism, or other diving accident(s)?

No ____ Yes ____

If Yes, fill in details:

Date _____ Location _____

Dive profile: Depth _____ fsw / Bottom time _____ min.

Equipment used _____ Type problem _____

Physical symptoms observed _____

Initial treatment _____

Follow-up treatment or problems _____

Have you been cleared to resume diving by a qualified Diving Physician?

Yes ____ No ____ Physician's Name: _____

Your signature: _____

Date: _____

Form date 12/96