

Medical Requirements Certificate



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(Medical Examiner: After completing examination, please mail directly to Medical Underwriter, Navy Mutual Aid Association at the above address, fax to 703-945-1441, or email image to underwriting@navymutual.org.)

NAME: _____ (Last, First, Middle) _____ (Social Security Number)

1. Based upon statements of the applicant, available medical records, observation and examination, has the applicant ever had or been treated for any disease or injury of:

A. Cardiovascular System (including abnormal blood pressure)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
B. Respiratory System	<input type="checkbox"/> YES	<input type="checkbox"/> NO
C. Gastrointestinal System	<input type="checkbox"/> YES	<input type="checkbox"/> NO
D. Genitourinary System	<input type="checkbox"/> YES	<input type="checkbox"/> NO
E. Musculoskeletal System	<input type="checkbox"/> YES	<input type="checkbox"/> NO
F. Neuropsychiatric System (including psychological)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
G. Any history of cancer or malignancy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
 2. Medications Prescribed or taken within the past year? (diagnosis, dates, and list with dosages) YES NO
 3. Have you had any other illness or injury (other than minor cold or flu) for which a physician or other practitioner was consulted; any disease or physical deformity; any surgical procedure or hospitalization? YES NO
 4. Have you used any tobacco or nicotine product within the past 12 months? YES NO
- Describe any "yes" responses in detail below (if needed, use additional sheets, signed and dated):

Clinical Evaluation:

5. Height: ____ ft. ____ in.
6. Blood Pressure(s): Systolic ____ Diastolic ____ Pulse ____
7. Weight _____
8. Cardiovascular: _____
9. Respiratory: _____
10. Gastrointestinal: _____
11. Musculoskeletal: _____
12. Neuropsychiatric: _____
13. EENT: _____

Blood Chemistry:

- | | |
|------------------|----------------------------------|
| Glucose: _____ | Triglycerides: _____ |
| BUN: _____ | Cholesterol: _____ |
| Alk Phos: _____ | HDL Chol: _____ |
| AST (SGOT) _____ | CHOL/HDL Ratio: _____ |
| ALT (SGPT) _____ | PSA: (Male Age 45 & Older) _____ |
| GGT: _____ | HIV: _____ |

Urinalysis:

- Protein: _____
- Glucose: _____
- EKG (age 45 & older: Include copy of EKG tracing)
- Findings: _____

REMARKS: _____

I certify I made a thorough examination as recorded on this ____ day of _____ 20__ and I find no abnormality of mind or body not noted on this report.

Examiner's Signature & Title _____ Examiner's Address & Stamp _____
 Phone: (____) _____