INDEPENDENT MEDICAL EXAMINATION COMMISSION

MEDICAL EXAMINATION REPORT

Name: _____ Date: _____

Age: _____ Sex: _____

Address: _____

Occupation: _____

Purpose of Examination: _____

Findings:

Height: _____ Weight: _____

Blood Pressure: _____

Pulse: _____

Vision: _____

Hearing: _____

Remarks: _____

Examining Physician

Signature: _____

Name: _____

License No.: _____