

First Name	Last Name	Initial	Phone
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Address	Birth Date mm/dd/yyyy	Other: work / cell (circle one)
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City	Province	Postal Code
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BC Driver's License		Driver Medical Form	
Valid? <input type="checkbox"/> yes <input type="checkbox"/> no	License Number:	Expires:	Completed: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> pending

Under 18? <input type="checkbox"/> yes <input type="checkbox"/> no	Parent / Guardian Name	Phone Number
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Financial Responsibility:

Self ICBC Worksafe VA Other _____ (specify)

Claim #	Contact Name	Phone #	Fax #
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Medical Information: (please attach any pertinent medical information and also fill in below)

Age Related	Cerebral Palsy	Spinal Cord Injury
Arthritis	Diabetes	Stroke
Amputation	Muscular Dystrophy	Paraplegia
Brain Injury	Multiple Sclerosis	Quadriplegia
Burns	Neurological Disorder	
SEIZURES	Date of last seizure	

Medications	Dosage	Visual Testing (20/20) <small>please attach test results</small>	
		Name	Date Seen
		Ophthalmologist:	
		Optometrist:	
		Goldman Field Test:	
		Notes	

Referring Physician:

Name	MSP#	Phone#	FAX
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Address	Date Signed:
	Signature