AMERICAN ACCESS CASUALTY COMPANY

[redacted]
7595400

PHYSICIAN'S REPORT

Name of Driver For Whom This Report Is Being Completed:

Policyholder:

Policy Number:	Producer Name:	Producer #:

Are there any restrictions currently appearing on your driver's license? ☐ No ☐ Yes, please explain:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This authorization permits you (the attending physician and optometrist) to furnish all informaton you may have regarding my condition while under your observation or treatment. This includes any history obtained, x-rays and physical findings, diagnoses and prognoses. You are authorized to provide this information to be used for the underwriting of automobile liability insurance.

Note: The policyholder/applicant, not this insurance company, must pay any fees required for completion of this form.

Signature of Driver for whom this report is being completed

X. _____ Date _____

The individual for whom this report is being completed or any person authorized to act as a representative of the individual is entitled to receive a copy of this form. This authorization shall remain valid for a period of 1 year from the time at which it was signed and dated.

TO BE COMPLETED BY PHYSICIAN OR OPTOMETRIST

1. Nature of Impairment or Illness

_____

_____

2. Duration of Impairment or Illness

_____

_____

3. Medication Types and Amounts

_____

_____

4. In your opinion, will the impairment, illness or prescribed medication adversely affect the ability of the Driver listed above to safely operator a motor vehicle? ☐ No ☐ Yes, please explain:

_____

_____

5. Please check off the appropriate boxes that reflect your patient's vision

Right Eye ☐ 20/20 ☐ 20/30 ☐ 20/40 Left Eye ☐ 20/20 ☐ 20/30 ☐ 20/40

Policy Number:

Name:

App ID Number: 0

Date: _____

Physician's Name (please print) _____

Physician's Signature _____

Optometrist's Name (please print) _____

Optometrist's Signature _____