CHUBB®

Standard Medical Report

Production Company:		**Date of Exam:**
Production Title:		**Medical Practitioner Details (& stamp):**
Name of Examinee:		
Date of Birth:		
Gender:	**Male / Female**	
Estimated Days/Weeks on Production:		
Examinees Role on Production:		

Pre-Examination Questions

Do you have any other conditions medical or otherwise that might affect your ability to perform your duties on this production?

Yes ☐ No ☐

Will you be performing any of your own stunts or any physical activities that require practice or training?

Yes ☐ No ☐

Are you now or will you at any time during the period of contract be in any other film, stage show or any other professional engagement?

Yes ☐ No ☐

Are you now or will you at any time during the period of production be involved in any potential hazardous or physical activities? If yes, please give details:

Yes ☐ No ☐

Have you missed any time on any production or tour in the last 3 years? If 'yes' please provide details:
Production/Tour / Days missed / Cause of absence:

Would you consider yourself in good health?

Yes ☐ No ☐

When was the last time you visited a Doctor and why?

Please give details of any treating Medical Practitioners:

Have you had, or are you waiting for results of any recent tests/investigations? Yes ☐ No ☐

If Yes, then please give details:

Please list all medications (prescription or over the counter) and reason for taking them:

CHUBB®

Have you had any significant change in weight (more than 10lbs/1stone/4kg) in the past year (other than pregnancy?):

Yes ☐ No ☐

Do you smoke / have you ever smoked? If Yes, how many per week?

Yes ☐ No ☐

Do you drink alcohol? If Yes, how many units per week?

Yes ☐ No ☐

Have you ever been treated for alcohol dependence or addiction, either as an inpatient or outpatient?

Yes ☐ No ☐

Current Symptoms - Do you have any current symptoms including but not limited to:

Abdominal pain, nausea, vomiting, constipation, appetite loss or weight loss?

Yes ☐ No ☐

Chest pain, coughing, wheezing, breathlessness, coughing up blood or sputum, chest tightness or palpitations?

Yes ☐ No ☐

Headaches, limb weaknesses, visual problems, limb problems, numbness or dizziness or fainting?

Yes ☐ No ☐

Urinary problems, urinary symptoms such as pain on passing urine, discharge, passing urine more frequently, discoloured urine, blood in the urine?

Yes ☐ No ☐

Ear, nose and throat problems such as sore throat, hoarse voice, sinusitis, cough, mucous, blood in the mucous, ear pain?

Yes ☐ No ☐

Skin; any skin lesions such as irritation, infection, bleeding or cold sores?

Yes ☐ No ☐

Musculoskeletal; any joint pains including upper and lower back, gout, swollen joints or muscle pains?

Yes ☐ No ☐

Dental; any pain, discomfort or bleeding of the teeth or gums?

Yes ☐ No ☐

Medical History – In the past 10 years, have you suffered from any of the following:

Heart disease including heart attack, chest pain, high blood pressure, heart irregularity or any other disorder of the heart or blood vessels such as DVT or blocked artery?

Yes ☐ No ☐

Any disorder of the chest including asthma, emphysema, persistent cough, fibrosis, pulmonary emboli, pneumonia, bronchitis or any other disease or abnormality of the lungs or respiratory system?

Yes ☐ No ☐

Any disorder of the eyes ear, nose or throat including sore throat, hoarse voice, laryngitis, sinusitis?

Yes ☐ No ☐

Cold sores on the lips or face?

Yes ☐ No ☐

Any disorder of the abdominal system including peptic ulcer, recurrent indigestion, vomiting, blood, rectal bleeding, diarrhoea or constipation, colitis or inflammatory bowel disease or any other abnormality of the stomach, intestines, rectum, liver, pancreas, gallbladder or any hernia?

Yes ☐ No ☐

Any disorder of the neurological system including persistent headache, migraine, stroke, convulsion, numbness, paralysis, or any other disorder of the brain or nervous system?

Yes ☐ No ☐

CHUBB®

Any arthritis, swollen joints, back pain, soft tissue problems including ligament or tendon problems or any other disorder or injury of the bones, joints, muscles, back, spine or neck?

Yes ☐ No ☐

Skin lesions including eczema, psoriasis, cellulitis, dermatitis or any other disorder of the skin?

Yes ☐ No ☐

Do you have any allergies?

Yes ☐ No ☐

Any abnormality of the blood including anaemia or any other disorder?

Yes ☐ No ☐

Any hormonal issue including diabetes, thyroid, adrenal or investigations for or abnormalities of the glands?

Yes ☐ No ☐

Any disorder of the urinary system including any kidney stones or disorder of the bladder, kidney or urogenital system and renal tract or investigations thereof and any lymph glands, any known cancers or tumours?

Yes ☐ No ☐

Counselling, or been on any medication or had to see a psychiatrist or been admitted into a psychiatric clinic for any reason?

Yes ☐ No ☐

Eating disorder, anxiety, panic attack or phobia?

Yes ☐ No ☐

Additionally, have you ever:

Been exposed to any infectious or tropical diseases?

Yes ☐ No ☐

Taken any recreational / non-prescription drugs in the past 10 years?

Yes ☐ No ☐

Had any CT or MRI scans or ultrasound scans, if so when?

Yes ☐ No ☐

Had any illnesses which would have prevented you from working, if you were working in the past five years?

Yes ☐ No ☐

Had any hospital admissions in the last 5 years?

Yes ☐ No ☐

Are you awaiting any specialist appointments? If 'Yes', please give full details:

Yes ☐ No ☐

Had any medical treatment or investigations in the past 5 years for any other reason not mentioned above?

Yes ☐ No ☐

Family History

Is there any family history of note such as cancer, heart disease / defects, stroke, chest problems, diabetes?

Yes ☐ No ☐

FEMALE Examinee's Only:

Have you ever had any abnormalities of your periods?

Yes ☐ No ☐

Have you ever had to see a gynaecologist and/or breast specialist/surgeon?

Yes ☐ No ☐

Have you ever been pregnant?

Yes ☐ No ☐

CHUBB®

Have you ever experienced complications during pregnancy?	Yes ☐ No ☐
To the best of your knowledge are you now pregnant; if so how many months?	Yes ☐ No ☐
Have you missed any smear tests or had any abnormal results in the last 3 years? If 'Yes', please give full details, including treatment:	Yes ☐ No ☐

MALE Examinee's Only:

Have you ever had any disease or abnormality of the prostate?	Yes ☐ No ☐
Have you ever had a PSA test? When was this and what were the results?	Yes ☐ No ☐

Examinee's Declaration

By signing this Form you consent to Chubb Insurance using the information we may hold about you for the purpose of providing Insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information or criminal convictions). This may mean we have to give some details to third parties involved in providing Insurance cover. These may include Insurance carriers, third party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities and the production company. Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to when the information relates both to the disclosure of such information to Insurers and its use by Insurers as set out above. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which Insurers may charge a small fee) and to have any inaccuracies corrected.

I DECLARE that I am the person named above; that the statements made by me are true and correct; that I have withheld no information known to me which might alter or otherwise conflict with the statements made by me. I understand that an insurance policy may be issued based on these statements made by me. If a policy is issued and a claim is paid I understand that the Insurer may seek recoupment from me if it is determined that the statements I have made are not true and correct, or that I have withheld information known to me which might alter or otherwise conflict with these statements I have made. I also agree to be examined by the Insurer's doctor in the event a claim is made.

I authorise Insurers to have access to my medical records for underwriting and claims purposes. I acknowledge that I may request a copy of this authorisation. I agree that this authorisation shall be valid for a period of six months or until any claim is resolved in which I am involved.

Examinee Name:	**Signed:**	**Date:**
Guardian Name: *(where examine is under 18yrs)*	**Signed:**	**Date:**

CHUBB®

Medical Practitioner Examination

General appearance:

Height:	Weight:	Blood Pressure:	Pulse:	Temp:
ENT:		Eyes:		
MSK (back, neck, limbs):				
Abdomen (inc Hernia's):				
CVS:	P:	BP:	HS:	
RS:	Trachea:	PN:	BS:	
GIS:	Masses:	Tenderness:	Liver/Speen:	
CNS:	Pupils:	Reflexes:	Skin:	

CHUBB®

Medical Practitioner Comments

Please comment on the Examinee's fitness to fulfil production obligations and on all replies given above:

Medical Practitioner's Declaration

I have today examined the above named person and in my opinion he/she is in sound health, is free from disease and is in a fit condition, subject to any qualifications mentioned above, to fulfil his/her role in the production.

Medical Practitioners Name:	Signed:	Date:
Qualifications:	Email:	Tel:

Data Protection Notice

We use personal information which you supply to us or, where applicable, to your insurance broker for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: https://www2.chubb.com/uk-en/footer/privacy-policy.aspx. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

Chubb. Insured.℠