# Cast Medical Certificate

**Section 1: ARTIST'S STATEMENT OF DECLARED HEALTH (Must be completed by artist show below)**

| Name of Artist | | Production Title | |
|---|---|---|---|
| Artist's Role | | Production Company | |
| Date of Birth / Sex | / / M / F | Filming Dates | First Day: Last Day: |

**1.** Have you to the best of you knowledge and belief, ever had or been informed you have/had:

a) Allergies, anemia or disorder of the blood? ☐ Yes ☐ No
b) Any disease, disorder or injury of the bones, joints, muscles, back, spine, or neck? ☐ Yes ☐ No
c) Any disorder of the skin, lymph glands, immune system, cyst, tumor or cancer? ☐ Yes ☐ No
d) Any infections or diseases of eyes, ears, nose or throat in the past 5 years? ☐ Yes ☐ No
e) Cold sores on lips or face in the past 5 years? ☐ Yes ☐ No
f) Convulsions, paralysis or stroke, fainting attack, severe headaches or disease of the brain or nervous system? ☐ Yes ☐ No
g) Diabetes, gout or any disease or abnormality of the thyroid or other glands? ☐ Yes ☐ No
h) Duodenal or gastric ulcer, colitis, or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas, gallbladder or hernia? ☐ Yes ☐ No
i) High blood pressure, heart attack, pain in chest, or any other disorder of the heart or blood vessels? ☐ Yes ☐ No
j) Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder of the bladder, kidney or genito-urinary system? ☐ Yes ☐ No
k) Tuberculosis, asthma, emphysema, persistent cough or any disease or abnormality of the lungs or respiratory system? ☐ Yes ☐ No
l) Any significant change of weight (20 lbs. or more or 10% of body weight) in the past year? ☐ Yes ☐ No
m) Treatment for any indication of excessive use of alcohol or drugs? ☐ Yes ☐ No
n) Any eating disorder? ☐ Yes ☐ No
o) Disorder of skin, lymph glands, cyst, tumor or cancer. ☐ Yes ☐ No

**2.** During the last twenty-one days, do you have reasons to believe that you been exposed to any infectious or contagious disease? ☐ Yes ☐ No

**3.** Are you currently using or in the last 12 months have you used:
a) Drugs (prescription or non-prescription), ☐ Yes ☐ No
b) Narcotics, depressants, stimulants, or psychedelic drugs, heroin or cocaine ☐ Yes ☐ No
c) Tobacco? Alcohol? Frequency? ☐ Yes ☐ No

**4.** In the past 5 years: consulted a doctor, been under a doctor's care, had surgical advice/treatment or been confined to a hospital? ☐ Yes ☐ No

**5.** In the past 3 years: missed any work time as a result of illness or injury while in any film or stage production? ☐ Yes ☐ No

**6.** Are you now or will you be at any time during the period of production involved in any stunt work or employed on or performing in any other film, stage or other professional engagement? If yes, Name of Production: ☐ Yes ☐ No

**7.** Are you now or will you at any time during the period of production be involved in any potentially hazardous physical activities or hazardous sports, including but not limited to auto/motorcycle racing, equestrian, gliding/flying/skydiving/mountain climbing, scuba diving, snow or water skiing, or other (please specify? ☐ Yes ☐ No

**8.** Has any insurance company declined to insure you or imposed any special terms in regard to your acceptance for any Cast Insurance, Non-Appearance Insurance or Accident, Health or Life Insurance? ☐ Yes ☐ No

**9.** Do you suffer from any phobias or are you aware of any mental health problems that may prevent you from carrying out your scheduled production activities? ☐ Yes ☐ No

**10.** Are there any other conditions (medical or otherwise) that might affect your ability to perform your duties on this production? ☐ Yes ☐ No

**11.** To be completed if the artist is a female: Have you had any disorder of menstruation, pregnancy or the female organs or breasts? To the best of your knowledge are you now pregnant? If yes, how many months? ☐ Yes ☐ No

**12.** To the best of your knowledge are you in good health and free from physical impairment or disease? If no, please explain. ☐ Yes ☐ No

**13.** In what location(s) will you be filming? Please indicate vaccinations taken for filming in any foreign locations.

**14.** Name, phone Number of your personal physician (If none, so state):
Last examined? Why? Results?

*AFFIDAVIT & AUTHORIZATION TO RELEASE INFORMATION*

I declare that I am the person named above, that the statements made by me on the pages of this Artist's Statement of Declared Health made hereon by me are true, correct and complete, and that I have not withheld information known to me which might alter or otherwise conflict with the statements made by me on this Statement.

I declare that, during the period of this production, I will continue to take any medications or follow any course of treatment currently prescribed to me by my personal physician(s) as indicated on this Statement.

I understand that coverage for insurance may be granted based upon the representations and facts stated by me on this Statement as true. If a policy is issued and a claim is paid there under, I understand that the insurer will hold me personally liable and seek recoupment from me or my estate if it is thereafter determined that the statements I made hereon are not true, correct and otherwise complete, or that I have withheld information known to me which might alter or otherwise conflict wtih the statements I have made. I further agree to cooperate with any claim investigation and to be reexamined by insurer's doctors in the event a claim is made.

I hereby direct, authorize and request any physician, medical practitioner, hospital, laboratory, health care provider, or other medical or medically related facility, insurance or reinsurance company to permit the insurer or its representatives, production company, insurance broker, or their agents to review and copy all medical reports, x-rays, charts, records and other data in the Medical Records Holders possession or control that pertain in any manner to my medical history, physical or mental condition, care and/or treatment. The Medical Records Holder is also authorized to discuss such information or provide a written report as necessary. This information is to be used for the purpose of processing, verifying, investigating and/or evaluating an application for insurance, a claim for insurance benefits or responsibility for payment or legal liability in relation to the above named production. This authorization shall be considered valid for twenty four (24) months from the date on which it is signed. A copy of this authorization shall be considered as valid as the original, and I am entitled to receive a copy of this authorization if I request such. I also consent to the release of any information gathered by Abacus Insurance Brokers, Inc. or the Insurance Company(s) to any production company, which may be considering me for a role.

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*Artist's Comments*

For any 'yes' answers, provide details on a separate page including diagnosis, treatment, results, dates of disability, degree of recovery and name and phone number of attending physician.

Signature of Artist or Legal Guardian: ____________________ Date: ____________________

# Cast Medical Certificate

**Section 2: PHYSICAL EXAMINATION (To be completed by the examining physician)**

Date of Examination ______________________________

Examining Physician ______________________________

Physician's Address ______________________________

Physician's Phone ______________________________

*General Appearance of Examined Artist*

| Height | ________ | Weight | ________ | Temp | ________ | Pulse | ________ |
|---|---|---|---|---|---|---|---|
| Blood Pressure | ________ | EENT | ________ | Heart | ________ | Lungs | ________ |
| Abdomen | ________ | | | | | | |

*Physician's Comments:* (Please complete any further examination you deem necessary as a result of your findings or Examinee's history and comment on any condition revealed by artist. Please include notes on examination and any abnormal findings and recommendations. If additional space is needed, please use additional pages)

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______________________________

In my professional opinion, the artist is ______is not_____ in sound health and free from disease and is in a fit condition, subject to any qualifications mentioned above, to fulfill his/her production/performance/engagement.

Signature of Physician ______________________________ Date: ______________

Date ______________________________

Qualifications/License of Physician ______________________________

*For Insurance Company Use Only*

- ☐ Accident & Accidental Death only
- ☐ Accident, Death & Sickness (unrestricted)
- ☐ Accident, Death & Sickness (restricted)
  Restrictions: