



CAST MEDICAL APPLICATION

1. Name of Production Company (Applicant): _____
2. Production: _____ Name of Applicant: _____
3. Estimated weeks working on production: _____ Date of Exam: _____ Hour: _____
4. Location: _____ Physician (please print): _____
5. Address: _____ Phone: _____

AFFIDAVIT OF EXAMINED PERSON

It is mandatory that the applicant answer the following questions: all yes answers to be explained in appropriate section on page 2:

6. Birth Date: _____ Age: _____ Sex: _____
7. Have you ever had, been advised you had or been treated for any of the following medical conditions:

	YES	NO
A. Convulsions, paralysis or stroke, fainting attacks; severe headaches or disease of the brain or nervous system?	_____	_____
B. High blood pressure, heart attack, pain in chest, or any other disorder of the hear or blood vessels?	_____	_____
C. Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs/respiratory system	_____	_____
D. Duodenal or gastric, ulcer, colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas Gallbladder or hernia?	_____	_____
E. Sugar, albumin, blood or pus in urine, kidney stones or any other disorder of the bladder, kidney, or genitor-urinary system?	_____	_____
F. Diabetes, gout or any other disease or abnormality of the thyroid or other glands?	_____	_____
G. Any disease, disorder or injury of the bones, joints, muscles, back, spine or neck?	_____	_____
H. Disorder of the skin, lymph glands, cyst, tumor or cancer?	_____	_____
I. Disorder of eyes, ears, nose or throat?	_____	_____
J. Cold sores on lips or face in past five years?	_____	_____
K. Allergies, anemia or other disorder of the blood?	_____	_____
L. Any eating disorder?	_____	_____
8. Have you had any significant change of weight (more than 10 lbs) or participate in diet programs? _____
9. Have you ever been treated for or had any indication of excessive use of alcohol or drugs? _____
10. During the last twenty one days have you been exposed to any infection or contagious disease? _____
11. Have you consulted a doctor or been under a doctors care, for any physical or mental condition during the past 5 years? _____
12. Have you had surgical advice or treatment or been confined to a hospital during the past 5 years? _____
13. Have you missed any time on any tour or production in the last 3 years? If yes, indicate below
 Production Title: _____ Days Missed: _____ Cause of Absence: _____
14. To the best of your knowledge, 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? _____
15. To be completed when the examinee is Female:
 - A. Have you had any disorder of menstruation, pregnancy or any of the female organs or breasts? _____
 - B. To the best of your knowledge are you now pregnant? _____
 - C. If so, how many months? _____ How many pregnancies have you had? Any complications? _____

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16. Name, Address and telephone number of your personal physician (if none, so state): _____

17. When was your last physical exam/check-up? _____ Results? _____
18. Are you now (or in the past 30 days) taking any medicine or health treatments? _____ State full particulars:

19. To the best of your knowledge and belief are you in good health and free from physical impairment or disease? _____
 If "no" give full details: _____
20. Are you now or will you at any time during a period of production be in any other film, stage or other professional engagement? _____
 State full particulars and dates: _____
21. Do you suffer from any phobias, or have you had or been treated for mental health problems that have in the past have caused you to be disabled or may in the future prevent you from carrying out your scheduled production activities?

22. Do you use tobacco in any form? _____
 For "yes" answers, give diagnosis, treatment, results, and dates of disability, degree of recovery, name and address of attending physician:

23. If under age 9, please advise what childhood diseases you have had, and attach a copy of immunization record:

24. Do you participate in any physical activities or sports on a regular basis, including but not limited to car racing, motorcycling, skiing, equestrian activity, marathon/triathlons, sky diving, gliding, scuba diving, mountain climbing and flying? If yes, which ones?

25. Please indicate all roles or responsibilities that you will have on this production: Leading Actor Supporting Actor
 Cameo Actor Director Director of Photography Exec Producer Co-Producer Producer
 Writer Other (please describe) _____
26. If your role is that of actor, what is the name of the character(s) that you are portraying? _____ Start Date: _____
27. Do you have contractual provisions stating the maximum number of hours that you may be required to work during any given day?
 If yes please indicate _____ Hours: _____
28. Do you have a stop date in your contract? If yes, please indicate date: _____
29. Will you be performing any special physical activities that require practice or special training? If yes, please explain:

I declare and affirm that I am the person first named above; that the statements made hereon by me are true, correct and complete; that I have withheld no information known to me which might alter or otherwise conflict with the statements made above by me. I further understand that a policy of insurance may issue based upon the representations and facts stated by me above as true. In the event a policy of insurance does issue and a claim is paid pursuant to the policy and it is determined later that the facts set forth above are not true, the insurer would seek recoupment from Examinee for such payment and hold Examinee fully liable for same. Examinee further agrees to be re-examined by Insurer's doctors in the event a claim is made.

 Signature of Applicant

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PHYSICAL EXAMINATION

30. General Appearance: _____ Height: _____ Weight: _____
31. Temperature : _____ Blood Pressure: _____ Pulse: _____ EENT: _____
32. Heart: _____ Lungs: _____

PHYSICIAN'S COMMENTS

Complete any further examination you deem necessary as a result of your findings or Examinee's history. Please contact on any special feature revealed by artist in his/her replies in the first part of this form with notes on examination and any abnormal findings and recommendations:

I have today examined the above named artist/performer and in my opinion he/she (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: _____

Qualification of Physician: _____

AUTHORIZATION TO PHYSICIANS OR PRACTITIONERS, HOSPITALS, INSURANCE COMPANIES OR OTHER INSTITUTES

I, the undersigned, hereby direct, authorize and request any physician, practitioner, hospital, laboratory, insurance company, or health care provider to permit the Insurer, or its duly authorized representative, to review and copy all medical reports, x-rays, charts, records, and other data in your possession or control which pertain in any manner to my medical history, physical condition, care and/or treatment.

You are also authorized to discuss with the Insurers any such medical history, physical condition, care and/or treatment and to furnish them with a written report regarding same. This information is to be used for the purpose of processing, verifying, investigating and/or evaluating my application for insurance, a claim for insurance benefits, responsibility for payment or legal liability.

This authorization shall be considered valid for thirty months from its date unless sooner revoked in writing by me and filed with the Insurer.

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.

Date: _____

Signature: _____