United States Parachute Association Date: ____________

CERTIFICATION OF PHYSICAL AND MENTAL FITNESS FOR SKYDIVING

(Required physical and psychological examination form for skydiving) ***OTHER FORMS WILL NOT BE ACCEPTED.***

PERSONAL INFORMATION

Name:	**Date of Birth:**	**Gender:** M F
USPA Membership # (if applicable)**:**	**License** (if applicable)**:**	☐

EXAMINATION

Height:	**Weight:**	**BP:** /	**Pulse:**
Vision Corrected: ☐ Yes ☐ No	R 20/	L 20/	**Pupils:** Equal / Unequal

MEDICAL PHYSICAL	**NORMAL**	**ABNORMAL**	**NOT TESTED**
Appearance			
Eyes/Ears/Nose/Throat/Hearing			
Lymph Nodes			
Heart (Murmurs, auscultation standing, supine)			
Lungs			
Abdomen			
Genitourinary (males)			
Skin (HSV, Lesions suggestive of MRSA, tinea corporis)			
Neurological			

MUSCULOSKELETAL	**NORMAL**	**ABNORMAL**	**NOT TESTED**
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

PSYCHOLOGICAL	**YES**	**NO**	**COMMENTS**
Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.			
Mental disorders of any sort; depression, anxiety, etc.			
Substance dependence or failed a drug test ever, or known use of illegal substance			
Alcohol dependence or abuse			
Suicide attempt			

CLEARANCE

☐ Cleared for all skydiving operations without restriction

☐ Cleared for all skydiving operations with recommendations for further evaluation, treatment, or modification: ____________

____

☐ Not Cleared ☐ Pending Further Evaluation Reason: ____________________________

I have examined the above-named individual and completed the pre-participation physical evaluation. The individual does not present apparent clinical contraindications to practice and participate in skydiving operations as outlined above. If conditions arise after the individual has been cleared for participation, USPA may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the individual.

Name of MD/DO/PA (print/type): ____________________________ Date: ______________

Address: ____

MD/DO/PA Signature: ____________________________ Phone: ______________