intact INSURANCE entertainment

Intact Entertainment
505 North Brand Blvd., Suite 1250
Glendale, CA 91203
License No. 0773887

Los Angeles
(781) 332-8400 Fax (866) 640-6533
New York
(212) 307-0111 Fax (212) 307-0598

MEDICAL CERTIFICATE

AFFIDAVIT OF EXAMINED PERSON

PLEASE PRINT

NAME OF EXAMINEE: _____

PRODUCTION TITLE: _____

PRODUCTION COMPANY: _____

DATE OF EXAM: _____ **LOCATION OF EXAM** _____

EXAMINEE'S ROLE: ☐ACTOR ☐DIRECTOR ☐OTHER

FIRST DAY OF FILMING: _____ **# OF WEEKS FILMING** _____

It is mandatory that the examinee answer the following:

1) Date Of Birth:_____ Age: _____ Sex:_____

2) Please circle the applicable letter if you have ever had, been advised you had, been treated for or consulted a doctor regarding any of the following medical conditions:
   - A. Convulsions, paralysis or stroke, severe headaches or diseases of the brain or nervous system.
   - B. High blood pressure, heart attack, angina pectoris or any other disorders of the heart or blood vessels.
   - C. Tuberculosis, asthma, emphysema, persistent cough or any other disease or abnormality of the lungs or respiratory system.
   - D. Duodenal or gastric ulcer, colitis or any other disease or abnormality of the stomach, intestines, rectum, liver, pancreas or gallbladder.
   - E. Sugar, albumin, blood or pus in urine, kidney stones, or any other disorder of the bladder, kidney or genitourinary 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 or spine.
   - H. Cold sores on lips or face in the past five years.
   - I. Any significant change of weight, (20 lbs. or more) in the past year.
   - J. Treatment for or any indication of excessive use of alcohol or drugs.
   - K. Any infection or disease of the eyes, ears, nose, throat or vocal cords.
   - L. Any eating disorder.
   - M. Disorder of skin, lymph glands, cyst, tumor or cancer.
   - N. Anxiety, disorders of moods (bi-polar), disorder of thoughts (hallucinations, amnesia).
   - O. Infectious diseases, including, but not limited to blood borne pathogens (i.e. hepatitis).

3) To be completed if artist is female:
   Have you had any disorder of menstruation, pregnancy or of the female organs or breasts? YES ☐ NO ☐
   To the best of your knowledge, are you now pregnant? YES ☐ NO ☐
   If yes, how many months?_____

4) In the past five years have you been under a doctor's care and/or been admitted to a hospital for any physical or mental condition?
   If yes, please state: YES ☐ NO ☐
   _____

5) Are there any other conditions, medical or otherwise, that might affect your ability to perform your duties on this production: YES ☐ NO ☐
   If yes, please state:_____

6) When did you last receive a complete physical examination? _____
   What were the results? _____

7) Name and address of personal physician: _____

8) Do you have any beliefs that preclude you from taking prescribed medication or treatment? YES ☐ NO ☐

9) Have you, within the past five years, been disabled as a result of any illness or injury while working in any film or stage production? YES ☐ NO ☐
   If yes, state full particulars, name of the production and dates:
   _____

10) Are you now, or will you at any time during the period of this production, be taking part in any other film or stage production or other professional engagement? YES ☐ NO ☐
    If yes, state full particulars and dates: _____
    _____

11) Are you currently using or in the last twelve months have you used:
    - A. Prescription or non-prescription drugs? YES ☐ NO ☐
    - B. Narcotics, depressants, anti-depressants, stimulants or psychedelic drugs (such as LSD), heroin or cocaine, whether prescribed by a physician or not: YES ☐ NO ☐

    Please explain any "Yes" answer under A or B above: _____
    _____
    - C. Tobacco? YES ☐ NO ☐ Amount/Frequency _____
    - D. Alcohol? YES ☐ NO ☐ Amount/Frequency _____

12) Will you be participating in any potentially hazardous activities or sports in your personal time during pre-production or principal photography of this film, 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 ☐
    If so, please state frequency (daily, weekly, etc.)
    _____

13) 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 ☐
    If yes, please explain:_____

14) Do you have any family history of heart or kidney disease or diabetes? YES ☐ NO ☐

15) Will you be performing any special physical activities in this production (e.g. running, climbing, weapon work, fight sequences, aerial, etc.)? YES ☐ NO ☐
    If yes, please explain: _____

16) In what location will you be filming? _____
    Please indicate vaccinations taken for filming in any foreign locations:
    _____

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 by me. I understand that an insurance policy may be issued based on the statement made hereon by me. 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 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 with the statements I have made. I also agree to be reexamined by the insurer's doctors, in the event a claim is made. Further, I authorize any physician, licensed practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, or production company having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me to give to Intact Entertainment and the Insurance Company(ies), and their affiliates, agents or brokers for underwriting and claim settlement purposes. I know that I may request a copy of this authorization. I agree that this authorization shall be valid for a period of two years from the date on which it was signed. I also consent to the release of any information gathered by Intact Entertainment or the Insurance Company(ies) to any production company, which may be considering me for a role.

_____

SIGNATURE OF EXAMINEE or LEGAL GUARDIAN PRINT NAME DATE SIGNED

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PHYSICIAN'S EXAMINATION

Name of Examining Physician: _____

Physician's Telephone Number: _____

Physician's Fax Number: _____

Artist Name: _____ Production Co./Title: _____

ARTIST'S GENERAL APPEARANCE

HEIGHT: _____ WEIGHT: _____ TEMP.: _____ BLOOD PRESSURE: _____

PULSE: _____ EENT: _____ HEART: _____ LUNGS: _____

If examinee is under the age of nine, please advise what childhood disease(s) he/she has had and provide immunization records:

_____

_____

Please provide details regarding any circled items per question 2, items A through M, or any YES answer for questions 3 through 15 on the examinee's Medical Certificate:

_____

_____

_____

_____

Were there any abnormal findings? _____

_____

FOR INSURANCE COMPANY USE ONLY:
Accepted for Full Coverage _____
Accepted for Accident Only _____
Rejected _____
Accepted subject to the following restrictions:
_____
_____
_____

_____
Signature of Physician

_____
Date Signed