

**FORM E – MEDICAL CONDITION**

**DUPLICATE** this form as necessary to complete a separate sheet for **EACH** condition. Use reverse side of this form if additional space is needed.

Applicant Name: \_\_\_\_\_  
Last First MI

A. Describe this medical condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?  
\_\_\_\_\_  
\_\_\_\_\_

C. What is the current status of your condition? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name				Telephone Number
_____	_____	_____	Degree	( ) _____
Last	First	MI	Degree	
_____	_____	_____	Degree	( ) _____
Last	First	MI	Degree	

Signature: \_\_\_\_\_ Date: \_\_\_\_\_