APPS
PARA MEDICAL SERVICES

M E A S U R E M E N T S

INSURANCE COMPANY: _____

PROPOSED INSURED: _____

DATE OF BIRTH: _____   **SS#: XXX-XX-** __ __ __ __
                                                            (Provide last four only)

Application/Policy #: _____   **Amount of Insurance: $** _____

GENDER   [   ] Male   [   ] Female

PHOTO ID   [   ] Yes   [   ] No

Type of ID used: _____

H E I G H T - W E I G H T

Complete all items and weigh client on a scale and measure with a tape.

HEIGHT: _____ feet _____ inches   **WEIGHT:** _____ pounds

Did you measure?   [   ] Yes   [   ] No
Did you weigh?   [   ] Yes   [   ] No

B L O O D   P R E S S U R E   &   P U L S E

1st Reading: _____ / _____   **Pulse** _____

2nd Reading: _____ / _____   **Irregularities** _____

3rd Reading: _____ / _____

_____   _____
Witness   (examiner signature)   **Proposed Insured (signature)**

_____
Paramedical Company   Street Address   City   State   Phone #

Date: _____   **Time:** _____ [   ]AM [   ]PM

NOTE: Follow Insurance Company's mailing instructions. If all paperwork to lab, please forward to their designated laboratory; otherwise image/mail to the Insurance Company.