The Medical Protective Company
Medical Condition Supplement

Please make additional copies if needed.

If answered "Yes" in Section IV to question E please complete the following:

If you have a medical condition, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of such an impairment, **a statement from your treating physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of condition:

_____

_____

Date(s) of treatment(s): From:____/____ To:____/____ ___ Currently in treatment
MM YYYY MM YYYY

Names of treating physician(s): _____

Address(es):_____