MEDPRO RRG RISK RETENTION GROUP
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): _____