## 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, <u>a statement from your treating physician attesting to your fitness to practice your specialty must accompany this application.</u>

Type(s) of condition:		
Date(s) of treatment(s): From:		 Currently in treatment
MM	YYYY	
Names of treating physician(s): Address(es):		

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