SUTTON
SPECIAL RISK

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Exclusion Review Form

To be completed by Insured Person's Attending Physician

1. Insured Person:_____
2. What is the condition/exclusion under review?_____
3. Date of initial accident/injury: _____
4. Diagnosis ofinjury/condition: _____
5. How much playing time was missed with respect to each injury/condition?

   _____
6. Results and dates of relevant x-rays, MRI's and/or C-T scans: _____

   _____
7. **If** spinal column involved, is there any suspicion of disc herniation or disease?_____
8. What treatment was prescribed? (**If** surgery was performed, include copy of operative notes)

   _____
9. How many games has the Insured Person participated in since the accident/injury?_____
10. What is Insured Person's current condition?_____
11. Is the Insured Person currently on any medication? (If yes, please including details including dosing.)

    _____
12. Does the Insured Person require any protective equipment since the injury? (For example, knee brace.)

    _____
13. What is the prognosis with respect to the Insured Person's ability to continue his career? _____
14. Any other comments that may influence the Insurer's decision: _____

    _____

Attending Physician's signature: _____ Date:_____

Attending Physician's name: _____ Phone #:_____

Address:_____

Fax #: _____ E-mail address: _____

If you have any questions with respect to the completion of this form, please contact:

1-800-461-3292