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 of injury/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 provide details including dosage etc.) _____
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: _____
    _____
    _____

Date: _____ Attending Physician's signature: _____

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 us at 1-800-461-3292 or fax (416) 366-4608.