A division of CFMWS
Une division des SBMFC

| Name: | |
|---|---|
| Service Number: | |

**Health Questionnaire - Details Section:**
**Note: If you answered "YES" in any question from 1 to 6 above please provide details:** If additional space is needed, use a separate sheet providing the information required including your name, service number (SN), signature and date and attach it to this application.

| Question Number (1 to 6) | M or S | Details, Diagnosis, Duration, Results | Date Treated mm yyyy | Treatment & Results | Name and address of Physician or clinic |
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| Member's Signature: | |
| Spouse's Signature: | |
| Date (dd-mmm-yyyy): | |