



REGISTRATION FORM

FAMILY DIVERS
MALDIVES

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SPB 3035, St Pauls Bay, Malta.

+960 9481472

PERSONAL DETAILS

Name _____ Date of Birth ____/____/____
Passport number _____
E-Mail _____ Phone Number: _____
Emergency Contact: Name & Relationship _____ Phone Number: _____
Arrival flight number _____ Arrival date _____ Arrival time _____
Departure flight number _____ Departure date _____ Departure time _____
How did you know about us?: Walk-in / Google Search / Facebook / TripAdvisor / Referral from: _____
Do you have any kind of food allergies? _____

DIVING DETAILS

Certification Agency _____ Level _____ Card Number _____
Logged Dives _____ Date of Last Dive ____/____/____ LogBook Available: YES / NO Card Available: YES / NO
Diving insurance company _____ Policy number _____
International Insurance Phone number: _____
Do you need 15lt tanks? (extra cost) YES / NO
Check this box in case you need to rent equipment:
If checked, please fill up the following information and provide your size numbers:

<input type="checkbox"/> BCD	<input type="checkbox"/> Fins	Height: _____ (cm)
<input type="checkbox"/> Regulator	<input type="checkbox"/> Mask	Weight: _____ (kg)
<input type="checkbox"/> Wetsuit	<input type="checkbox"/> Reef Hook	Shoe Size: _____ (EU)
<input type="checkbox"/> Buoy (SMB)	<input type="checkbox"/> Computer	

Complete the information below only if you are joining a Live Aboard

Check this box if you are **Nitrox certified**:

Nitrox certification agency: _____ Nitrox certification number: _____

GDPR consent

You may have heard about the new *General Data Protection Regulation* (“GDPR”), that comes into effect May 25, 2018. To help comply with GDPR consent requirements, we need to confirm that you would like to receive content from us. We hope that our content is useful to you. If you'd like to continue hearing from us, please select “YES” on the following box: YES / NO

Date ____/____/____

Participant Name _____ Parent/Guardian Name _____

Participant Signature _____ Parent/Guardian Signature _____



Diving issues you should be aware of when diving in the Maldives. Your booking conditions with Family Divers Maldives and Orca hereafter called “FDM” and/or “Orca”.

In signing this form, I acknowledge that I have read and agree to its contents and understand the implications and risks involved. I agree to follow the safe diving practices of my training organization(s).

DIVING: I agree not to exceed the maximum limit nor exceed the non-decompression limits (NDL) under any circumstances barring a life threatening emergency. I also understand that it is my responsibility to check to what depths my insurance provides cover. I understand that should I break this rule FDM reserves the right to stop me diving with no refund for diving packages.

FDM dive guides will provide a detailed and comprehensive dive briefing before I enter the water with my buddy, when the guide is in the water they will remain with the group to navigate the site and to look out for any interesting marine life to show me. I am aware that the guide will not provide any training during the dive and I, and my buddy pair, dive at our own risk. As a qualified diver I am responsible for my own and my buddy's safety during the dive and to plan my dive and dive my plan by using a personal dive computer. I must begin, execute and end the end with my dive buddy.

I confirm that I have been advised and informed of the inherent hazards of skin and scuba diving. I understand that skin and scuba diving can cause physical strain or exertion, not normally experienced in non-diving situations.

I assume all risks connected with scuba diving and will not hold FDM responsible for any injuries including but not limited to those resulting from heart attack, physical / mental strain or exertion, or barotrauma, including decompression sickness or arterial gas embolism.

ENRICHED AIR NITROX: I agree to abide by the maximum operating depth (MOD) applicable to my level of training and the gas mix used. I agree to personally analyse cylinders for my use and completion the fill station log.

MEDICAL: I confirm that I have no current or historic illness, disease or medical condition, which could lead to the injury of myself, any other diver or employee of FDM, whilst skin or scuba diving. I agree to complete the medical statement that is a requirement laid down by the Maldivian Authorities. If I am in doubt as to my health, past or present and the effect this may have on dive safety, I agree to be independently examined prior to diving.

I agree not to drink any alcoholic beverages before I dive. I give FDM my permission to stop me from diving should I drink any alcoholic beverages before diving or if I am still under the influence of alcohol before diving. I agree not to dive after use of medication or when feeling unwell.

COVID-19: FDM has conformed to all national regulations regarding limiting the spread of coronavirus while in FDM facilities or Orca boats. There will be safety information provided to guests by way of posters and briefing. It is my responsibility to follow the procedures outline and use personal and FDM provided resources to protect myself and others from spreading coronavirus. I in no way hold FDM responsible if it is assumed or confirmed I contract coronavirus while in a FDM facility or Orca boat.

EMERGENCY: I agree to bear all the costs of medical treatment, chamber costs, recovery and transport charges in the event of an accident, injury or disease. Should the case arise that I am unable to decide for myself I authorise FDM and their agents to arrange medical treatment on my behalf. I will provide FDM with details of my insurance company, policy number and Medical telephone number. I do understand that if any accident happens, it might take some time to reach a medical centre, so I will abide to safety standards and listen carefully to the instructions of FDM employees.

BOAT SAFETY: Extra due care and attention is required when diving, operating and living on boats due to the increased hazard of, but not restricted to, movement in rough seas, wet decks and equipment movement. I undertake to take extra care whilst on board a boat and will not hold FDM responsible for any damages incurred that can be attributed to normal boating hazards. I accept the increased risk of diving near to and from dhonis and accept that extra care and vigilance is required on my behalf.

NATURE: I understand that there is marine life that may cause bodily injury if touched or harassed and therefore I agree not to feed, touch or harass the marine life. I will not wear gloves.

EQUIPMENT: FDM maintains scuba equipment for service on a rental basis. This equipment is not in any way guaranteed either as to correct construction or safe use. Parties renting and using this equipment will do so entirely upon their own judgement and at their own risk. I have inspected the equipment and find that it is in good working order and free from defects. I agree to return the equipment at the end of rental period in the same condition, fair wear and tear expected, and will be responsible for the loss or damage to the said equipment including freight charges and import duty. Equipment returned late is subject to a late charge. No refunds will be paid due to non-use of equipment. Rentals are per 24-hour or part period. A security deposit is required on all rentals. FDM is not responsible for any damages or losses of any equipment whether the property of the client or FDM.

I agree that FDM will not be held liable or responsible for an injury I sustain as a result of not adhering to the above terms.

INSURANCE: Orca is a Maldivian company and is governed under Maldivian law. Orca has "Dive Assist" liability cover for diving activities. FDM and Orca insist that guests have adequate personal diving and non-diving insurance to cover all diving and non-diving risks involved in the service provided by FDM and Orca. IT IS MY RESPONSIBILITY to check that my insurance provides adequate cover and that I dive within the limits of the cover provided. Chamber costs are high in the Maldives. We also advise that it is important to have good travel insurance to cover accidents of a general nature.

JURISDICTION: The contract between you and FDM is made on the terms of these booking conditions which are governed by Maldivian Law and clients shall be subject to the sole jurisdiction of the Maldivian courts.

Full Name: _____

Signed: _____ **Date:** _____



Diver Medical | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

Directions

Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.

Note to women: If you are pregnant, or attempting to become pregnant, *do not dive*.

1	I have had problems with my lungs, breathing, heart and/or blood affecting my normal physical or mental performance.	Yes <input type="checkbox"/> Go to box A	No <input type="checkbox"/>
2	I am over 45 years of age.	Yes <input type="checkbox"/> Go to box B	No <input type="checkbox"/>
3	I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
4	I have had problems with my eyes, ears, or nasal passages/sinuses.	Yes <input type="checkbox"/> Go to box C	No <input type="checkbox"/>
5	I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
6	I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease.	Yes <input type="checkbox"/> Go to box D	No <input type="checkbox"/>
7	I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning or developmental disability.	Yes <input type="checkbox"/> Go to box E	No <input type="checkbox"/>
8	I have had back problems, hernia, ulcers, or diabetes.	Yes <input type="checkbox"/> Go to box F	No <input type="checkbox"/>
9	I have had stomach or intestine problems, including recent diarrhea.	Yes <input type="checkbox"/> Go to box G	No <input type="checkbox"/>
10	I am taking prescription medications (with the exception of birth control or or anti-malarial drugs other than mefloquine (Lariam).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Participant Signature

If you answered **NO** to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

Participant Statement: I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

_____	_____
Participant Signature (or, if a minor, participant's parent/guardian signature required.)	Date (dd/mm/yyyy)
_____	_____
Participant Name (Print)	Birthdate (dd/mm/yyyy)
_____	_____
Instructor Name (Print)	Facility Name (Print)

* If you answered **YES** to questions 3, 5 or 10 above **OR** to any of the questions on page 2, please read and agree to the statement above by signing and dating it **AND take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

Diver Medical | Participant Questionnaire Continued

BOX A – I HAVE/HAVE HAD:		
Chest surgery, heart surgery, heart valve surgery, an implantable medical device (eg, stent, pacemaker, neurostimulator), pneumothorax, and/or chronic lung disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Symptoms affecting my lungs, breathing, heart and/or blood in the last 30 days that impair my physical or mental performance.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX B – I AM OVER 45 YEARS OF AGE AND:		
I currently smoke or inhale nicotine by other means.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have a high cholesterol level.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have high blood pressure.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX C – I HAVE/HAVE HAD:		
Sinus surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Ear disease or ear surgery, hearing loss, or problems with balance.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurrent sinusitis within the past 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Eye surgery within the past 3 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX D – I HAVE/HAVE HAD:		
Head injury with loss of consciousness within the past 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Persistent neurologic injury or disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Recurring migraine headaches within the past 12 months, or take medications to prevent them.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Blackouts or fainting (full/partial loss of consciousness) within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Epilepsy, seizures, or convulsions, OR take medications to prevent them.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX E – I HAVE/HAVE HAD:		
Behavioral health, mental or psychological problems requiring medical/psychiatric treatment.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care or special accommodation.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An addiction to drugs or alcohol requiring treatment within the last 5 years.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX F – I HAVE/HAVE HAD:		
Recurrent back problems in the last 6 months that limit my everyday activity.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Back or spinal surgery within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Diabetes, either drug or diet controlled, OR gestational diabetes within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
An uncorrected hernia that limits my physical abilities.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
BOX G – I HAVE HAD:		
Ostomy surgery and do not have medical clearance to swim or engage in physical activity.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Dehydration requiring medical intervention within the last 7 days.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD).	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Active or uncontrolled ulcerative colitis or Crohn's disease.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>
Bariatric surgery within the last 12 months.	Yes <input type="checkbox"/> *	No <input type="checkbox"/>

Diver Medical | Medical Examiner's Evaluation Form

The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.

Evaluation Result

- Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.
- Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

Signature of certified medical doctor or other legally certified medical provider Date (dd/mm/yyyy)

Medical Examiner's Name

(Print)

Clinical Degrees/Credentials

Clinic/Hospital

Address

Phone **Email**

Physician/Clinic Stamp (optional)

Created by the [Diver Medical Screen Committee](#) in association with the following bodies:
The Undersea & Hyperbaric Medical Society
DAN (US)
DAN Europe
Hyperbaric Medicine Division, University of California, San Diego