ANNEX – D
A. O. No. 2013-0006

NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL CERTIFICATE FOR SERVICE AT SEA

Approved and authorized by the Department Of Health (DOH)and the Maritime Industry Authority (MARINA) of the Republic of the Philippines Issued in compliance with STCW Convention, 1978, as amended Section A-I/9 Paragraph 7 and the Maritime Labour Convention, 2006

SURNAME/LAST NAME: SERRANO	GIVEN/FIRST NAME: BERNARD	MIDDLE NAME: ABADILLA
AGE: 48	DATE OF BIRTH: 20 DAY 4 MONTH 1975 YEAR	PLACE OF BIRTH: PASIG CITY
		NATIONALITY: FILIPINO
GENDER. MALE ☒ FEMALE ☐	CIVIL STATUS: SINGLE ☒ MARRIED ☐	RELIGION: ROMAN CATHOLIC
ADDRESS: 143 LUBYUTO ST., AYIZILUHNA AVE. PASIG CITY		
PASSPORT NUMBER: 420W33D	SEAMAN'S BOOK NUMBER. 5MOK3EV	
POSITION ON BOARD: DECK ☐ ENGINE ☐ CATERING ☒ OTHERS ☐ SPECIFY_____		COMPANY: SHURMOLHUNG

DECLARATION OF THE AUTHORIZED PHYSICIAN

CONFIRMATION THAT IDENTIFICATION DOCUMENTS WERE CHECKED AT THE POINT OF EXAMINATION·	YES ☐	NO ☐
HEARING MEETS THE STANDARDS IN STCW CODE, SECTION A-1/9?	YES ☐	NO ☐
UNAIDED HEARING SATISFACTORY?	YES ☐	NO ☐
VISUAL ACUITY MEETS STANDARDS IN STCW CODE, SECTION A-I/9?	YES ☐	NO ☐
COLOUR VISION MEETS STANDARDS IN STCW CODE, SECTION A-I/9? Date of last colour vision test: (Day/ Month/ Year) ____/____/____	YES ☐	NO ☐
VISUAL AIDS (tick if worn) SPECTACLES ☐ CONTACT LENSES ☐		
FIT FOR LOOKOUT DUTIES?	YES ☐	NO ☐
NO LIMITATIONS OR RESTRICTIONS ON FITNESS? if "NO" specify limitations or restrictions· _____	YES ☐	NO ☐
IS APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY SERVICE AT SEA OR TO RENDER THE SEAFARER UNFIT FOR SUCH SERVICE OR TO ENDANGER THE HEALTH OF OTHER PERSONS ON BOARD?	YES ☐	NO ☐

PHOTO
(MUG SHOT)
PASSPORT SIZE

THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO

_____
(NAME OF SEAFARER)

RESULT:
FIT FOR DUTY. ☐ UNFIT FOR DUTY ☐

_____
NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN
DATE OF EXAMINATION DAY/MONTH/YEAR ____/____/____

APPROVED BY·

_____
MEDICAL DIRECTOR

OFFICIAL STAMP

NAME OF ISSUING AUTHORITY. _____
ADDRESS. _____

PHYSICIAN'S CERTIFYING AUTHORITY. _____
PHYSICIAN'S LICENSE NUMBER: _____

I HAVE READ AND UNDERSTOOD AND WAS INFORMED OF THE CONTENTS OF THE CERTIFICATEAND OF THE RIGHT TO A REVIEW IN ACCORDANCE WITH PARAGRAPH 6 OF SECTION A-I/9 OF THE STCW CODE.

SEAFARER'S NAME AND SIGNATURE: _____ DATE: _____
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

DATE OF ISSUANCE:DAY/ MONTH/ YEAR	DATE OF EXPIRATION: DAY/ MONTH/ YEAR