MEDICAL CERTIFICATE FOR SERVICE AT SEA

**CONFIDENTIAL**

(In accordance with IMO STCW.7/Circ.19/Rev.1 “Guidelines on the medical examinations of seafarers”)

|  |  |  |
| --- | --- | --- |
| Family Name |  | |
| Given Names |  |  |
| Date of birth (day/month/year) |  | Sex:  Male  Female |
| Home address |  | |
| Passport No./Discharge Book No.:  Nationality: |  | |
| Department | Deck  Engine  Radio  Food handling  Other | |
| Routine and emergency duties  (if known) |  | |
| Type of ship (container, tanker, passenger, fishing) |  | |
| Trade area (e.g., coastal, tropical, worldwide) |  | |

## A. EXAMINEE’S PERSONAL DECLARATION

*(Assistance should be offered by medical staff)*

Have you ever had any of the following conditions?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | *Condition* | *Yes* | *No* |  | *Condition* | *Yes* | *No* |
| 1. 1 | Eye/vision problem |  |  |  | Sleep problems |  |  |
| 1. 2 | High blood pressure |  |  |  | Do you smoke, use alcohol or drugs? |  |  |
| 1. 3 | Heart/vascular disease |  |  |  | Operation/surgery |  |  |
|  | Heart surgery |  |  |  | Epilepsy/seizures |  |  |
|  | Varicose veins/ hemorrhoids |  |  |  | Dizziness/fainting |  |  |
|  | Asthma/bronchitis |  |  |  | Loss of consciousness |  |  |
|  | Blood disorder |  |  |  | Psychiatric problems |  |  |
|  | Diabetes |  |  |  | Depression |  |  |
|  | Thyroid problem |  |  |  | Attempted suicide |  |  |
|  | Digestive disorder |  |  |  | Loss of memory |  |  |
|  | Kidney problem |  |  |  | Balance problem |  |  |
|  | Skin problem |  |  |  | Severe headaches |  |  |
|  | Allergies |  |  |  | Ear (hearing, tinnitus)/nose/throat problems |  |  |
|  | Infectious/contagious diseases |  |  |  | Restricted mobility |  |  |
|  | Hernia |  |  |  | Back or joint problems |  |  |
|  | Genital disorders |  |  |  | Amputation |  |  |
|  | Pregnancy |  |  |  | Fractures/dislocations |  |  |
| If any of the above questions were answered “yes”, please give details. | | | | | | | |

**Additional questions**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Yes | No |
|  | Have you ever been signed off as sick or repatriated from a ship? |  |  |
|  | Have you ever been hospitalised? |  |  |
|  | Have you ever been declared unfit for sea duty? |  |  |
|  | Has your medical certificate ever been restricted or revoked? |  |  |
|  | Are you aware that you have any medical problems, diseases or illnesses? |  |  |
|  | Do you feel healthy and fit to perform the duties of your designated position/occupation? |  |  |
|  | Are you allergic to any medications? |  |  |
| Comments: | | | |
|  | Are you taking any non-prescription or prescription medications? |  |  |
| If yes, please list the medications taken and the purpose(s) and dosage(s) | | | |

I hereby certify that the personal declaration above is a true statement to the best of my knowledge.

Signature of examinee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (day/month/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Witnessed by: *(Signature)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: *(typed or printed)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorise the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the approved medical examiner).

Signature of examinee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (day/month/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Witnessed by: *(Signature)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: *(typed or printed)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and contact details for previous medical examination (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B. MEDICAL EXAMINATION**

**Sight:**

Use of glasses or contact lenses:  Yes  No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if yes, specify which type and for what purpose)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Visual acuity | | | | | |  |  | Visual fields | |
|  | Unaided | | | Aided | | |  |  |  |  |
|  | Right eye | Left eye | Bino-cular | Right eye | Left eye | Bino-cular |  |  | Normal | Defective |
| Distant |  |  |  |  |  |  |  | Right eye |  |  |
| Near |  |  |  |  |  |  |  | Left eye |  |  |

**Colour vision:**  Not tested  Normal  Doubtful  Defective

**Hearing/9:**

Pure tone and audiometry (threshold values in dB) Speech & whisper test (metres)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 500 Hz | 1000 Hz | 2000 Hz | 3000 Hz |  |  |  |  | Normal | Whisper |
| Right ear |  |  |  |  |  |  |  | Right ear |  |  |
| Left ear |  |  |  |  |  |  |  | Left ear |  |  |

Clinical findings:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Height | cm | | Weight | kg |
| Pulse rate | ( / minute) | | Rhythm |  |
| Blood pressure: Systolic | | mm Hg | Diastolic | mm Hg |
| Urinalysis: | Glucose | | Protein | Blood |

Normal Abnormal Normal Abnormal

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Head |  |  | Skin |  |  |
| Sinuses, nose, throat |  |  | Varicose veins |  |  |
| Mouth/teeth |  |  | Vascular (inc pedal pulses) |  |  |
| Ears (general) |  |  | Abdomen and viscera |  |  |
| Tympanic membrane |  |  | Hernia |  |  |
| Eyes |  |  | Anus (not rectal exam) |  |  |
| Ophthalmoscopy |  |  | G-U system |  |  |
| Pupils |  |  | Upper & lower extremities |  |  |
| Eye movement |  |  | Spine (C/S, T/S and L/S) |  |  |
| Lungs and chest |  |  | Neurologic (full/ brief) |  |  |
| Breast examination |  |  | Psychiatric |  |  |
| Heart |  |  | General appearance |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Chest X-ray | Not performed | Performed on (day/month/year): | \_\_\_/\_\_\_/\_\_\_\_ |
| Results: | | | |

**Other diagnostic test(s) and result(s):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Test | Result | | | | |
| Haemoglobin “Hb” | g/dl | | | | |
| Hepatitis B | HBsAg | negative | | | positive |
| Stool - Bacteria\*¹ | not performed | | negative | positive | |
| Stool - Ova and Parasites\*¹ | not performed | | negative | positive | |
| ECG \*² |  | | | | |
| HIV (+ or -) | negative  positive | | | | |
| Drug & Alcohol\*³ | Pass  Fail  Not performed | | | | |
| Additional screening tests at Examiner’s discretion (list type of test and result) |  | | | | |
| Medical examiner’s comments and assessment of fitness, with reasons for any limitations: | | | | | |
| \*¹required by the Company for food handlers only  \*² required by the Company for crew members over 40 years of age  \*³ required for newly hired seafarers only (before their 1st contract with the Company) | | | | | |

**Assessment of fitness for service at sea:**

On the basis of the examinee’s personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically:

Fit for look-out duty  Not fit for look-out duty

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Deck service | Engine service | Catering service | Other services |
| Fit |  |  |  |  |
| Unfit |  |  |  |  |

Without restrictions  With restrictions Visual aid required:  Yes No

|  |
| --- |
| Describe restrictions (e.g., specific position, type of ship, trade area): |

Date medical certificate issued: (day/month/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Certificate is valid until date (day/month/year): \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Number of medical certificate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of medical examiner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Medical practitioner information (name, license number, address): |

Crew member: please take this original in an envelope with you on board and hand it out to the doctor.