**MEDICAL CERTIFICATE FOR SERVICE AT SEA**

CONFIDENTIAL

(in accordance with ILO/IMO/JMS/2011/12 ‘Guidelines on medical examinations of seafarers)

On board passenger vessels, worldwide trading

|  |  |
| --- | --- |
| Family Name |  |
| Given Names |  |
| Date of birth (day/month/year) |  |
| Home address |  |
| Passport Number |  |
| Nationality |  |
| Department | Deck  Engine  Food handling Other |
| Watch keeper | Yes No |
| Sex | Female Male |
| Number of contracts | First contract on Silversea vessel Returning crew |

1. **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. Eye/vision problem   18. Sleep problems
2. High blood pressure   19. Do you smoke, use alcohol or drugs
3. Heart/vascular disease   20. Operation / surgery
4. Heart surgery   21. Epilepsy/seizures
5. Varicose veins/hemorrhoids   22. Dizziness/fainting
6. Asthma/bronchitis   23. Loss of consciousness
7. Blood disorder   24. Psychiatric problems
8. Diabetes   25. Depression
9. Thyroid problem   26. Attempted suicide
10. Digestive disorder   27. Loss of memory
11. Kidney problem   28. Balance problem
12. Skin problem   29. Severe headaches
13. Allergies   30. Ear (hearing, tinnitus/nose/throat problems)
14. Infectious/contagious diseases   31. Restricted mobility
15. Hernia   32. Back or joint problems
16. Genital disorders   33. Amputations
17. Pregnancy   34. Fractures/dislocations

If any of the above questions were answered ‘yes’ please give details under ‘comments’

**Additional questions:** yes no

35. Have you ever been signed off as sick or repatriated from a ship?

36. Have you ever been hospitalized?

37. Have you ever been declared unfit for sea duty?

38. Have you ever been restricted or revoked?

39. Are you aware that you have any medical problems, diseases or illnesses?

40. Do you feel healthy and fit to perform the duties of your designated position/occupation?

41. Are you allergic to any medication?

If so, do you carry an Epi Pen?

42. Are you taking any non-prescription of prescription medication?

43. Have you had the influenza vaccine?

44. Have you had a covid vaccine?

If so: Name of vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ number of doses\_\_\_\_

Dates of administration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

45. Have you had any surgery in the past six months? If so please list below

46. Do you have any recurrently episodes of diarrhea? If so please comment below

Comments (please add #)

|  |
| --- |
|  |

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 authorize 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **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 | Binocular | Right eye | Left eye | Binocular |  |  | 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.