DOH ACCREDITATION NUMBER

13-012-2022-MF-2

# ARGUELLES MEDICAL

*THE POWER OF HEALTH FOR THE WORLD'S WORKFORCE*

1271 Zobel Roxas, Malate, 1004 Manila, Philippines
Tels: (632) 521-5353 * (632) 3030-752 * Fax: (632) 526-8052
a-md.com

## MEDICAL CERTIFICATE FOR SERVICE AT SEA

*Approved 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: | GIVEN/FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| SOLER | REYNALDO | ELLOREN |

| AGE: | DATE OF BIRTH: (day / month / year) | PLACE OF BIRTH: | NATIONALITY: |
|---|---|---|---|
| 58 | 09-April-1961 | ISABELA BASILAN | FILIPINO |

| GENDER: | CIVIL STATUS: | RELIGION: |
|---|---|---|
| MALE ☑ FEMALE ☐ | SINGLE ☐ MARRIED ☑ | CATHOLIC |

ADDRESS: 476 5TH ST. SOUTHCOM VILL ZAMBOANGA CITY

| PASSPORT NO.: | SEAMAN'S BOOK NUMBER: |
|---|---|
| P2212882A | C0848218 |

| POSITION APPLIED FOR: | COMPANY: |
|---|---|
| MASTER<br>DECK: ☑ ENGINE: ☐ STEWARD: ☐ OTHERS: ☐ _____ | CONAUTIC MARITIME, INC. |

**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 ☐ |
| COLOR VISION MEETS STANDARDS IN STCW CODE, SECTION A-I/9?<br>Date of the last colour vision test: (Day/Month/Year) **29/1/2020** | YES ☑ | NO ☐ |
| VISUAL AIDS (tick if worn) SPECTACLES ☑ CONTACT LENSES ☐ | | |
| FIT FOR LOOKOUT DUTIES? | YES ☑ | NO ☐ |
| NO LIMITATIONS OR RESTRICTIONS ON FITNESS? | YES ☑ | NO ☐ |

IF "NO" specify limitations or restrictions:

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 ☑

SOLER, REYNALDO ELLOREN
29-Jan-20 08:47

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

REYNALDO ELLOREN SOLER
NAME OF SEAFARER

**RESULT:**

FIT FOR SEA DUTY: ☑ UNFIT FOR SEA DUTY: ☐

KATRINA LEI V. MORALES, M.D.
NAME AND SIGNATURE OF EXAMINING / AUTHORIZED PHYSICIAN

DATE OF EXAMINATION: 29-January-2020

APPROVED BY:

WILFREDO JOSE P. ARGUELLES JR., M.D.
License No.: 73645
MEDICAL DIRECTOR

NAME OF ISSUING AUTHORITY: ARGUELLES MEDICAL CLINIC, INC
ADDRESS: 1271 Roxas, Malate, 1004 Manila, Philippines
PHYSICIAN'S CERTIFYING AUTHORITY: PROFESSIONAL REGULATION COMMISSION
PHYSICIAN'S LICENSE NO.: 122974

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

SEAFARER'S NAME AND SIGNATURE: REYNALDO ELLOREN SOLER DATE: 29-January-2020
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

DATE OF ISSUANCE: (day / month / year) 03-February-2020

DATE OF EXPIRATION: (day / month / year) 28-January-2022



CONTROL NO.: 20200129-0016

DOH ACCREDITATION NUMBER
13-012-2022-MF-2

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# MEDICAL EXAMINATION REPORT

*Approved 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: | FIRST NAME: | MIDDLE NAME: |
|---|---|---|
| SOLER | REYNALDO | ELLOREN |

| AGE: | DATE OF BIRTH: (day / month / year) | PLACE OF BIRTH: | NATIONALITY: |
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| 58 | 09-April-1961 | ISABELA BASILAN | FILIPINO |

| GENDER: | CIVIL STATUS: | RELIGION: |
|---|---|---|
| MALE ☑ FEMALE ☐ | SINGLE ☐ MARRIED ☑ | CATHOLIC |

ADDRESS: 476 5TH ST. SOUTHCOM VILL ZAMBOANGA CITY

PASSPORT NUMBER.: P2212882A SEAMAN'S BOOK (SIRB) NUMBER: C0848218

POSITION APPLIED FOR: MASTER
DECK: ☑ ENGINE: ☐ STEWARD: ☐ OTHERS: ☐

NAME OF COMPANY: CONAUTIC MARITIME, INC.

**I. MEDICAL HISTORY** - Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions:
Place a check marks ( ✓ ) in the appropriate box ☐.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Head or neck injury | YES ☐ | NO ☑ | Other Lung Disorders | YES ☐ | NO ☑ | Gynaecological Disorders | YES ☐ | NO ☑ |
| Frequent headaches | YES ☐ | NO ☑ | High Blood Pressure | YES ☐ | NO ☑ | Last Menstrual Period | | |
| Frequent Dizziness | YES ☐ | NO ☑ | Heart Disease/ Vascular / Chest Pain | YES ☐ | NO ☑ | Kidney or Bladder Disorder | YES ☐ | NO ☑ |
| Fainting spells, fits or seizures or Other Neurological Disorders | YES ☐ | NO ☑ | Rheumatic fever | YES ☐ | NO ☑ | Back Injury / Joint Pain / Arthritis | YES ☐ | NO ☑ |
| Insomia or Sleep Disorders | YES ☐ | NO ☑ | Diabetes Mellitus | YES ☐ | NO ☑ | Genetic, Hereditary or Familial Disorders | YES ☐ | NO ☑ |
| Depression, Other Mental Disorders | YES ☐ | NO ☑ | Other Endocrine Disorders (e.g. Goiter) | YES ☐ | NO ☑ | Sexually Transmitted Disease | YES ☐ | NO ☑ |
| Eye Problems / Error of Refraction | YES ☐ | NO ☑ | Cancer or tumor | YES ☐ | NO ☑ | Tropical Diseases (e.g. Malaria, Typhoid Fever) | YES ☐ | NO ☑ |
| Deafness, Other Ear Disorders | YES ☑ | NO ☐ | Blood Disorders | YES ☐ | NO ☑ | Schistosomiasis | YES ☐ | NO ☑ |
| Nose or Throat Disorders | YES ☐ | NO ☑ | Stomach Pain, Gastritis or Ulcer | YES ☐ | NO ☑ | Asthma | YES ☐ | NO ☑ |
| Tuberculosis | YES ☐ | NO ☑ | Other Abdominal Disorder | YES ☐ | NO ☑ | Allergies Specify: | YES ☐ | NO ☑ |

Previous Hospitalization(s) / Operation(s) :

Place a check marks ( ✓ ) in the appropriate box ☐.

| | YES | NO |
|---|---|---|
| 1, Have you ever been signed off as sick or repatriated from a ship? | ☐ | ☑ |
| 2. Have you ever been hospitalized? | ☐ | ☑ |
| 3. Have you ever been declared unfit for sea duty? | ☐ | ☑ |
| 4. Has your medical certificate ever been restricted or revoked? | ☐ | ☑ |
| 5. Are you aware that you have any medical problem, disease or illness? | ☑ | ☐ |
| 6. Do you feel healthy and fit to perform the duties of your designated position/occupations? | ☑ | ☐ |
| 7. Are you allergic to any medication? | ☐ | ☑ |
| 8. Are you taking any non-prescription or prescription medication? If yes, please list the medication(s) taken/being taken, and the purpose(s) and dosages(s): PRAVASTATIN | ☑ | ☐ |

**II. MEDICAL EXAMINATION**
Enter the data called for. Place a check marks ( ✓ ) in the appropriate box ☐.

| HEIGHT (cm): | WEIGHT (kg): | BLOOD PRESSURE: | PULSE RATE: 78 / min | RESPIRATION: 19.. /min | BMI: |
|---|---|---|---|---|---|
| 171 | 68 | Systolic: 130 (mm Hg) Diastolic: 70 (mm Hg) | RHYTHM: | | 23.26 |

| VISUAL ACUITY | FAR VISION | | NEAR VISION | | ISHIHARA COLOR VISION | EAR: | Hearing by Audiometry | CLARITY OF SPEECH |
|---|---|---|---|---|---|---|---|---|
| Uncorrected | OD 20 / 40 | OS 20 / 40 | ODJ .37M | OSJ .37M | Adequate ☑ | Right | ☑ Adequate ☐ Inadequate | Adequate ☐ |
| Corrected | OD 20 / 20 | OS 20 / 25 | ODJ .37M | OSJ .37M | Defective ☐ | Left | ☑ Adequate ☐ Inadequate | Defective ☐ |



CONTROL NO.: 20200129-0016

II. MEDICAL EXAMINATION. (Continuation). Alongside columns A, B, C, put a check mark (✓) under "YES" if normal. If not Normal, specify findnigs.

| A | YES | Significant Findings | B | YES | Significant Findings | C | YES | Significant Findings |
|---|---|---|---|---|---|---|---|---|
| Skin | ☑ | | Neck, Lymph Nodes, Thyroid | ☑ | | Genito-urinary System | ☑ | |
| Head, neck, scalp | ☑ | | Chest-Breast-Axilla | ☑ | | Inguinals, Genitals | ☑ | |
| Eyes, external | ☑ | | Lungs | ☑ | | Extremities | ☑ | |
| Pupils, Ophthalmoscopic | ☑ | | Heart | ☑ | | Reflexes | ☑ | |
| Ears | ☑ | | Abdomen | ☑ | | Dental (Teeth/Gums) | ☑ | |
| Nose, Sinuses | ☑ | | Back | ☑ | | | | |
| Mouth, Throat | ☑ | | Anus-Rectum | ☑ | | | | |

III. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (✓) in the appropriate box ☐

| | | |
|---|---|---|
| A. CHEST X-RAY: ☑ Normal ☐ With Findings | D. URINALYSIS: ☑ Normal ☐ With Findings | G. HIV / AIDS Test: ☐ Reactive ☐ Non-Reactive NOT REQUIRED |
| B. ECG: ☐ Normal ☑ With Findings | E. STOOL EXAM: ☐ Normal ☐ With Findings NOT REQUIRED | H. TPHA: ☐ Reactive ☑ Non-Reactive |
| C. CBC: ☑ Normal ☐ With Findings | F. HEPATITIS B: ☐ Reactive ☑ Non-Reactive | I. VDRL: ☐ Reactive ☐ Non-Reactive NOT REQUIRED |
| PSYCHOLOGICAL TEST: ☑ Normal ☐ For Further Evaluation ☐ Not Required | | J. BLOOD TYPE (Specify): O |

ADDITIONAL TEST(S): (Specify): e.g. Blood Chemistry, Drug Test, Alcohol Test, Liver Function Test, Stool Culture, etc.

FBS/CREA/BUA-NORMAL
CHOLE (6.45)

IV. SUMMARY. Place a check mark (✓) in the appropriate box ☐

| | | |
|---|---|---|
| Basic DOH Mandatory Medical Examination: | ☑ PASSED | ☐ WITH SIGNIFICANT FINDINGS |
| Additional Laboratory Tests: | ☑ PASSED | ☐ WITH SIGNIFICANT FINDINGS |
| Flag / Host Medical and Laboratory Requirements: | ☑ PASSED | ☐ WITH SIGNIFICANT FINDINGS |

REMARKS / SPECIAL NEEDS (Specify e.g. with medication, diet restriction etc.)

NSSTTWC, HYPERCHOLESTEROLEMIA WITH MEDICATION, CLEARED BY CARDIOLOGIST; PASSED HEARING STANDARD USING HEARING AID; MUST BRING SPARE EYEGLASSES; MEDICALLY FIT FOR WORK AT THE TIME OF EXAMINATIONS

V. ASSESSMENT OF FITNESS FOR SERVICE AT SEA. Place a check mark (✓) in the appropriate box ☐

On the basis of the examiner'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 | ☑ MASTER | ☐ | ☐ | ☐ |
| UNFIT | ☐ | ☐ | ☐ | ☐ |

WITH RESTRICTIONS: ☐ WITHOUT RESTRICTIONS: ☑ VISUAL AIDS REQUIRED: YES ☑ NO ☐

Describe restrictions ** (refer to standard restrictions at the bottom of this page).

| DATE OF MEDICAL EXAMINATION: | DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: | MEDICAL EXAMINATION REPORT NO. |
|---|---|---|
| 29-January-2020 | 28-January-2022 | 20200129-0016 |
| DAY MONTH YEAR | DAY MONTH YEAR | |

NAME AND SIGNATURE OF EXAMINING / AUTHORIZED PHYSICIAN KATRINA LEI V. MORALES, M.D.

LICENSE NUMBER: 122974

ADDRESS: **1271 Roxas, Malate, 1004 Manila, Philippines**

I hereby certify that the personal declaration above is true to the best of my knowledge and I fully understand the above results of my medical examination as explained to me by the examining / authorized physician.

I hereby authorize the release of all my medical records to the DOH / MARINA / POEA, the examining / authorized physician and my employer/manning agency (**CONAUTIC MARITIME, INC.**).

REYNALDO ELLOREN SOLER
NAME AND SIGNATURE OF SEAFARER
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

29-Jan-2020
DATE



CONTROL NO.: 20200129-0016