



PHYSICIANS' DIAGNOSTIC SERVICES CENTER FOR SEABASED WORKERS, INC.

DOH Accreditation # 13-002-1820-MF-2



533 UNITED NATIONS AVENUE
PHYSICIANS' TOWER, ERMITA, MANILA, PHILIPPINES
Tel. No. 523-7832 Email: pdsesw@pdsclinics.com

Rev. No. 00
Rev. Date 00
Issue Date 08-Jan-2018



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-1/9 Paragraph 7 and the Maritime Labour Convention, 2006

SURNAME/LAST NAME: ADORNADO		GIVEN NAME: JOMON		MIDDLE NAME: ALIS
AGE: 41	DATE OF BIRTH: 01 Apr 1978	PLACE OF BIRTH: MANILA	NATIONALITY: FILIPINO	
CIVIL STATUS: SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/>		GENDER: MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	RELIGION: ROMAN CATHOLIC	
ADDRESS: BLOCK 6 LOT 11 SAINT ANDREW STREET SPS 7 SAN BARTOLOME NOVALICHES QUEZON CITY				
PASSPORT NO: P1860876B	SEAMAN'S BOOK (SIRB) NUMBER: C1185380		COMPANY: CONAUTIC MARITIME INC.	
POSITION APPLIED FOR: DECK <input checked="" type="checkbox"/> ENGINE <input type="checkbox"/> CATERING <input type="checkbox"/> OTHERS <input type="checkbox"/> PLEASE SPECIFY <u>ABLE SEAMAN</u>				
DECLARATION OF THE AUTHORIZED PHYSICIAN				
CONFIRMATION THAT IDENTIFICATION DOCUMENTS WERE CHECKED AT THE POINT OF EXAMINATION:			Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
HEARING MEETS THE STANDARDS IN STCW CODE, SECTION A-1/9?			Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
UNAIDED HEARING SATISFACTORY?			Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
VISUAL ACUITY MEETS STANDARDS IN STCW CODE, SECTION A-1/9?			Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
COLOR VISION MEETS STANDARDS IN STCW CODE, SECTION A-1/9?			Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Date of last color vision test: (Day/Month/Year) 11 Jul 2019				
VISUAL AIDS (tick if worn) SPECTACLES <input type="checkbox"/> CONTACT LENSES <input type="checkbox"/>				
FIT FOR LOOKOUT DUTIES?			Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
NO LIMITATIONS OR RESTRICTIONS ON FITNESS If "NO" specify limitations or restrictions:			Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
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 THE OTHER PERSONS ON BOARD?			Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
		<p>THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO: ADORNADO, JOMON ALIS (NAME OF SEAFARER)</p> <p>RESULT: FIT FOR SEA DUTY: <input checked="" type="checkbox"/> UNFIT FOR SEA DUTY: <input type="checkbox"/></p> <p>KIM GABRIEL T. MAGTIBAY, M.D. NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN</p> <p>DATE OF EXAMINATION: 11 Jul 2019</p> <p>APPROVED BY: PEDRO S. DE GUZMAN, M.D., FPCOM LIC. NO. 0029271 MEDICAL DIRECTOR</p>		
		<p>NAME OF ISSUING AUTHORITY: KIM GABRIEL T. MAGTIBAY, M.D.</p> <p>ADDRESS: 4th Flr. Physicians' Tower 533 United Nations Avenue, Ermita, Manila</p> <p>PHYSICIAN'S CERTIFYING AUTHORITY: P.R.C.</p> <p>PHYSICIAN'S LICENSE NUMBER: LIC. NO. 138048</p>		
I HAVE READ AND UNDERSTOOD AND WAS INFORMED OF THE CONTENTS OF THE CERTIFICATE AND OF THE RIGHT TO A REVIEW IN ACCORDANCE WITH PARAGRAPH 6 OF SECTION A-1/9 OF THE STCW CODE.				
SEAFARER'S NAME AND SIGNATURE: ADORNADO, JOMON ALIS		DATE: 16 Jul 2019		
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)				
DATE OF ISSUANCE OF PEME CERTIFICATE: (DAY/MONTH/YEAR) 16 Jul 2019		DATE OF EXPIRATION OF PEME CERTIFICATE: (DAY/MONTH/YEAR) 16 Jul 2021		



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MEDICAL EXAMINATION REPORT FOR SEAFARERS

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-1/9 Paragraph 7 and Maritime Labour Convention, 2006

Surname/Last Name: ADORNADO		Given Name: JOMON		Middle Name: ALIS	
Age: 41	Date of Birth: 01 Apr 1978	Place of Birth: MANILA		Nationality: FILIPINO	
Gender: Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>	Civil Status: Single <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>		Religion: ROMAN CATHOLIC		
Address: BLOCK 6 LOT 11 SAINT ANDREW STREET SPS 7 SAN BARTOLOME NOVALICHES QUEZON CITY					
Passport No: P1860876B		Seaman's Book (SIRB) Number: C1185380			
Position applied for: DECK <input checked="" type="checkbox"/> ENGINE <input type="checkbox"/> CATERING <input type="checkbox"/> OTHERS <input type="checkbox"/> (Specify) ABLE SEAMAN					
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 mark (✓) in the appropriate box ☐

Head or Neck Injury	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Other Lung Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Gynecological Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Frequent Headaches	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	High Blood Pressure	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Last Menstrual Period Specify Date	
Frequent Dizziness	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Heart Disease/Vascular/ Chest Pain	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Kidney or Bladder Disorder	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Fainting Spells, Fits, Seizures or Other Neurological Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rheumatic Fever	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Back injury/Joint Pain/ Arthritis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Insomnia or Sleep Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Diabetes Mellitus	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Genetic, Hereditary or Familial Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Depression, other Mental Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Other Endocrine Disorders e.g. Goiter	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Sexually Transmitted Disease	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Eye Problems/ Error of Refraction	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Cancer or Tumor	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Tropical Diseases (e.g. Malaria) Typhoid Fever - Specify Date)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Deafness, Other Ear Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Blood Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Schistosomiasis (Specify Date)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Nose or Throat Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Stomach Pain, Gastritis or Ulcer	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Asthma	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Tuberculosis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Other Abdominal Disorders	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Allergies (Specify)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Hemorrhoids	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Heart Surgery	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Varicose Veins	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Skin Problems	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Infectious / Contagious Diseases	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Hernia	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Loss of Consciousness	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Attempted Suicide	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Restricted Mobility	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Fracture / Dislocation	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Balancing Problem	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Operation(s) (Specify)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

Previous Hospitalizations / Operation(s):
NONE

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

- Have you ever been signed off as sick or repatriated from a ship?
- Have you ever been hospitalized?
If yes, please specify below
- 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 problem, disease or illness?
- Do you feel healthy and fit to perform the duties of your designated position/occupation?
- Are you allergic to any medication? Comments:
- Are you taking any non-prescription or prescription medications?
If yes, please list the medication(s) taken/being taken, and the purpose(s) and dosage(s)

YES	NO
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input checked="" type="checkbox"/>

II. MEDICAL EXAMINATION

Enter the data called for. Place a check mark (✓) in the appropriate box ☐ along side A, B, C, put a check mark (✓) under "Yes" if Normal, If not Normal, specify findings.

HEIGHT(cm) 167.00	WEIGHT (kg) 64.00	BLOOD PRESSURE Systolic: 110 (mm Hg) Diastolic: 80 (mm HG)	PULSE RATE: 74 /min RHYTHM: REGULAR	RESPIRATION 18 /min	BMI 23.02 kg/m2
VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION	EAR	Hearing by Audiometry
Uncorrected	OD 20/20 OS 20/20	ODJ .62 OSJ .62	Adequate <input checked="" type="checkbox"/>	Right <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
Corrected	OD OS	ODJ OSJ	Defective <input type="checkbox"/>	Left <input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
					<input type="checkbox"/> Defective

II. MEDICAL EXAMINATION (Continuation). Alongside Columns A, B, C, put a check mark (✓) under 'YES' if Normal. If not Normal, specify findings.

A	YES	Significant Findings	B	YES	Significant Findings	C	YES	Significant Findings
Skin	<input checked="" type="checkbox"/>		Neck, Lymph Nodes, Thyroid	<input checked="" type="checkbox"/>		Genito-Urinary System	<input checked="" type="checkbox"/>	
Head, Neck, Scalp	<input checked="" type="checkbox"/>		Chest-Breast-Axilla	<input checked="" type="checkbox"/>		Inguinals, Genitals, Hernia	<input checked="" type="checkbox"/>	
Eyes, External	<input checked="" type="checkbox"/>		Lungs	<input checked="" type="checkbox"/>		Extremities	<input checked="" type="checkbox"/>	
Pupils, Ophthalmoscopic	<input checked="" type="checkbox"/>		Heart	<input checked="" type="checkbox"/>		Reflexes	<input checked="" type="checkbox"/>	
Ears	<input checked="" type="checkbox"/>		Abdomen	<input checked="" type="checkbox"/>		Dental (Teeth/Gums)	<input checked="" type="checkbox"/>	
Nose, Sinuses	<input checked="" type="checkbox"/>		Back	<input checked="" type="checkbox"/>		Dental Significant Findings CLEARED		
Mouth, Throat	<input checked="" type="checkbox"/>		Anus-Rectum	<input checked="" type="checkbox"/>				

OTHER FINDINGS

BODY TEMPERATURE - 36.2°C

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

A. CHEST X-RAY: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> With Findings	D. URINALYSIS: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> With Findings	G. HIV/AIDS Test: <input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Non-reactive <input type="checkbox"/> Not Required
B. ECG: <input type="checkbox"/> Normal <input checked="" type="checkbox"/> With Findings	E. STOOL EXAM: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> With Findings <input type="checkbox"/> Not Required	H. TPHA: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input checked="" type="checkbox"/> Not Required
C. CBC: <input checked="" type="checkbox"/> Normal <input type="checkbox"/> With Findings	F. Hepatitis B: <input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Non-reactive <input type="checkbox"/> Not Required	I. RPR and/or VDRL: <input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Non-reactive <input type="checkbox"/> Not Required
PSYCHOLOGICAL TEST (when required): <input checked="" type="checkbox"/> Normal <input type="checkbox"/> For Further Evaluation	J. BLOOD TYPE (Specify): Type O	<input checked="" type="checkbox"/> *RH Factor

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

*CHEMICAL TEST - NORMAL
*BLOOD CHEMISTRY - NORMAL
*DRUG AND ALCOHOL TEST - NEGATIVE
*CARCINO EMBRYONIC ANTIGEN - NEGATIVE
*ECG - SINUS RHYTHM, LEFT AXIS DEVIATION, INCOMPLETE RIGHT BUNDLE BRANCH BLOCK / 2D ECHO WITH DOPPLER - NORMAL, UPGRADED TO INSIGNIFICANT FINDINGS; CLEARED BY CARDIOLOGIST

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

Basic DOH mandatory Medical Examination:	<input checked="" type="checkbox"/> PASSED	<input type="checkbox"/> WITH SIGNIFICANT FINDINGS
Additional Laboratory Tests:	<input checked="" type="checkbox"/> PASSED	<input type="checkbox"/> WITH SIGNIFICANT FINDINGS
Flag/Host Country Medical and Laboratory Requirements:	<input checked="" type="checkbox"/> PASSED	<input type="checkbox"/> WITH SIGNIFICANT FINDINGS

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

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

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 ☒

DECK SERVICE

ENGINE SERVICE

NOT FIT FOR LOOK-OUT DUTY ☐

CATERING SERVICE

OTHER SERVICES

FIT ☒

UNFIT ☐

WITH RESTRICTIONS: ☐

WITHOUT RESTRICTIONS: ☒

VISUAL AIDS REQUIRED

YES ☐

NO ☒

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

DATE OF MEDICAL EXAMINATION

11 Jul 2019

DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT:

This certificate is valid until 16 Jul 2021

MEDICAL EXAMINATION REPORT NO.

20190711-0048-SW

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN:

KIM GABRIEL T. MAGTIBAY, M.D.

LICENSE NUMBER:

LIC. NO. 138048

ADDRESS:

Physicians' Tower Bldg., 533 United Nations Avenue, Ermita, Manila

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, PHYSICIANS' DIAGNOSTIC SERVICES CENTER, INC. and my employer /manning agency (CONAUTIC MARITIME INC.).

ADORNADO, JOMON ALIS

NAME AND SIGNATURE OF SEAFARER

THE SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

16 Jul 2019

DATE

****STANDARD RESTRICTIONS (Duties):**

- No solo watchkeeping
- Not fit for emergency duties
- Not fit for lookout duties
- Only fit for lookout during daylight hours
- Not fit for work with colour coded tables etc
- Not to be away from (home) port overnight
- Not to be away from (home) port for periods over 24 hours / 7 days

- Not to work with.....(specify)
- Not fit for food handling
- Within.....(specify) miles from a safe haven
- Near - coastal only
- Coastal waters only, up to.....(specify) miles from shore
- Non-tropical waters only
- Not fit for service on stand-by vessels

- Not to lift items weighing over 5/10/20/40 kg
- Protective gloves to be worn for work with (specify)
- Eye protection to be worn for all work
- Fit for service only vessels with ship's doctor
- Toilet/washing facilities in private cabin required
- Special needs...in emergencies (specify)