

# **AI and Machine Learning Challenge**

## **Week 1**

1. Download the DOH forms provided by the platform.
2. Print out the DOH forms.
3. Filled up the print out forms with the dummy data using handwriting.
4. Scanned the filled up forms.
5. Log in to aws.amazon.com, go to Amazon Textract.
6. Upload the scanned filled up forms to Amazon Textract to get the extracted text.
7. Goto <https://combinepdf.com/> combine pre-filled forms and extracted text into PDF file.
8. Click the PDF file and open it with google chrome, click the print button, put the Destination into “Save as PDF”, put the Pages per sheet into “2” and then click Save.
9. Compare the pre-filled forms to the extracted text side by side and determine which characters it got wrong. See if there are patterns that emerge from these errors.

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

SURNAME/LAST NAME:	BUZ	GIVEN/FIRST NAME:	THANE	MIDDLE NAME:	C
AGE:	30	DATE OF BIRTH:	10/07/1987	PLACE OF BIRTH:	EGYPT
GENDER:	MALE	SEX:	FEMALE	CIVIL STATUS:	SINGLE
ADDRESS:	Bula, Wenzon				
PASSPORT NUMBER:	123456789				
POSITION ON BOARD:	DECK	ENGINE	CATERING	OTHERS	SPECIFY
COMPANY:	260				
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"/>					
COLOUR VISION MEETS STANDARDS IN STCW CODE, SECTION A-1/9? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
Date of last colour vision test (Day Month Year) / /					
VISUAL AIDS (check 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? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<p>THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO  <b>Shone Cruz</b>          (NAME OF SEAFARER)</p> <p>RESULT: <input checked="" type="checkbox"/>          FIT FOR DUTY: <input checked="" type="checkbox"/></p> <p>NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN          DATE OF EXAMINATION YOAY/MONTH/YEAR 10 / 11 / 23</p> <p>APPROVED BY:           MEDICAL DIRECTOR</p> <p>NAME OF ISSUING AUTHORITY:          ADDRESS:</p> <p>OFFICIAL STAMP</p> <p>PHYSICIAN'S CERTIFYING AUTHORITY:          PHYSICIAN'S LICENSE NUMBER:</p>					
<p>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-1/9 OF THE STCW CODE.</p> <p>SEAFARER'S NAME AND SIGNATURE:           (THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)</p> <p>DATE OF ISSUANCE: DAY/MONTH/YEAR          DATE OF EXPIRATION: DAY/ MONTH/ YEAR          DOH-PME-SB          Revision 01          10/17/2013</p>					
<p>DATE: 09.03.2023          (THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)</p> <p>DATE OF ISSUANCE: DAY/MONTH/YEAR          DATE OF EXPIRATION: DAY/ MONTH/ YEAR          DOH-PME-SB          Revision 01          10/17/2013</p>					
<p>Page 2</p>					

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

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-1/9?  
 YES  
 NO  
 COLOUR VISION MEETS STANDARDS IN STCW CODE, SECTION A-1/9?  
 YES  
 NO  
 Date of last colour vision test: (Day/Month/Year)  
 /  
 /  
 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  
 THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO  
 Shone Cruz  
 (NAME OF SEAFARER)  
 PHOTO  
 RESULT:  
 FIT FOR DUTY.  
 UNFIT FOR DUTY  
 (MUG SHOT)  
 GOOD  
 PASSPORT SIZE  
 NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN  
 DATE OF EXAMINATION YOAY/MONTH/YEAR 10 / 11 / 23  
 APPROVED BY:  
 MEDICAL DIRECTOR  
 of  
 NAME OF ISSUING AUTHORITY.  
 ADDRESS.  
 OFFICIAL STAMP  
 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



Republic of the Philippines  
Department of Health

**HEALTH FACILITIES AND SERVICES REGULATORY BUREAU**

**ANNEX-G**  
**A.O. No. 2013-0006**

**TABULATED PSYCHOLOGICAL EVALUATION FORM**

Name: **SHANE CRUZ** /  
Position Applied for: **DECK CREW**  
Referred by:  
Date of Examination: **10/11/2023**

**TEST ADMINISTERED**

Intelligence Test (IQ):  
Personality Test:  
Others:

**I. INTELLECTUAL LEVEL:**

- ( ) Very Superior      ( ) Average      ( ) Mentally Deficient  
( ) Superior              ( ) Below Average  
(✓) Above Average      ( ) Borderline

**II. PERSONALITY TRAITS AND CHARACTERISTICS:**

SENSE OF RESPONSIBILITY	1 Very Low	2 Low	3 Low Average	4 Average	5 High Average	6 High	7 Very High
Perseverance				✓			
Obedience				✓			
Self-discipline/Orderly				✓			
Enthusiasm				✓			
Initiative				✓			

EMOTIONAL STABILITY	1	2	3	4	5	6	7
Can withstand boredom and work alone				✓			
Tolerance to stress, pressures and inconveniences				✓			
Faces reality				✓			
Confidence				✓			
Relaxed				✓			

OBJECTIVITY	1	2	3	4	5	6	7
Tough-mindedness				✓			
Adaptability				✓			
Practicality				✓			

MFOWS-Annex G-Psychological Evaluation Form  
Revision 02  
12/08/2014  
Page 1 of 2

Republic of the Philippines  
Department of Health  
(MFOWS)  
HEALTH FACILITIES AND SERVICES REGULATORY BUREAU  
ANNEX-G

A.O. No. 2013-0006

TABULATED PSYCHOLOGICAL EVALUATION FORM

Name: **SHANE CRUZ**

Position Applied for: **DECK CREW**

Referred by:

Date of Examination: **10/11/2023**

TEST ADMINISTERED

Intelligence Test (IQ):

Personality Test:

Others:

I.

INTELLECTUAL LEVEL:

- ( ) Very Superior  
( ) Average  
( ) Mentally Deficient

- ( ) Superior  
( ) Below Average

- (✓) Above Average  
( ) Borderline

S)

Above Average

( ) Borderline

II.

PERSONALITY TRAITS AND CHARACTERISTICS:

SENSE OF

- 1  
2  
3  
4  
5  
6  
7

RESPONSIBILITY

- Very  
Low  
Low

- Average

- High

- High

- Very

- Low

- Average

- High

- Perseverance

- 

- Obedience

- /

Self-discipline/Orderly

/

Enthusiasm

/

Initiative

/

EMOTIONAL

1

2

3

4

5

6

7

STABILITY

Can withstand boredom

and work alone

/

Tolerance to stress,

pressures and

inconveniences

/

Faces reality

-

Confidence

/

Relaxed

OBJECTIVITY

1

2

3

4

5

6

7

Tough-mindedness

/

Adaptability

Practicality

MFOWS-Annex G-Psychological Evaluation Form

Revision:02

12/08/2014

Page 1 of 2

MOTIVATION	1	2	3	4	5	6	7
Assertiveness				-			
Independence				//			
Resourcefulness				//			

INTERPERSONAL AND PERSONAL ADJUSTMENT	1	2	3	4	5	6	7
Relationship with Peers and Co-workers (Team membership)							/
Relationship with Superiors, Employers and Authority Figures (Deference)							/
Self-esteem						/	
Aggressive Tendencies				/			

GOAL-ORIENTATION	1	2	3	4	5	6	7
Directs one's effort towards clear cut objectives				/			

I. CONCLUSION/REMARKS:

RECOMMENDED

No significant personality problems noted at the time of evaluation.

( ) FOR FURTHER EVALUATION

LEGEND:

- 1- Very Low
- 2- Low
- 3- Low Average
- 4- Average
- 5- High Average
- 6- High
- 7- Very High

MOTIVATION  
 1  
 2  
 3  
 4  
 5  
 6  
 7  
 -  
 Assertiveness  
 Independence  
 /  
 Resourcefulness  
 /  
 INTERPERSONAL  
 1  
 2  
 3  
 4  
 5  
 6  
 7  
 AND PERSONAL ADJUSTMENT  
 Relationship with Peers and Co-workers (Team membership)  
 /  
 Relationship with Superiors, Employers and Authority Figures (Deference)  
 Self-esteem  
 Aggressive Tendencies  
 GOAL-  
 1  
 2  
 3  
 4  
 5  
 6  
 7  
 ORIENTATION  
 Directs one's effort towards Clear cut objectives  
 I.  
 CONCLUSION/REMARKS:  
 RECOMMENDED  
 No significant personality problems noted at the time of evaluation.  
 ( ) FOR FURTHER EVALUATION  
 LEGEND:  
 1- Very Low  
 2- Low  
 3- Low Average  
 4- Average  
 5- High Average  
 6- High  
 7- Very High  
 DOE  
 Psychologist  
 MFOWS-Annex G-Psychological Evaluation Form  
 Revision:02  
 12/08/2014  
 Page 2 of 2

  
 JOHN DOE  
 Psychologist

MFOWS-Annex G-Psychological Evaluation Form  
 Revision:02  
 12/08/2014  
 Page 2 of 2

**NAME OF CLINIC**  
DOH ACCREDITATION NUMBER  
Clinic Address  
Clinic Contact Information  
Email Address

**MEDICAL CERTIFICATE FOR LANDBASED OVERSEAS WORKERS**  
Approved and authorized by the Department of Health (DOH)

SURNAME/LAST NAME: <b>CRUZ</b>	GIVEN NAME: <b>SHANE</b>	MIDDLE NAME: <b>C</b>
AGE: <b>36</b>	DATE OF BIRTH: <b>01/13/1987</b>	PLACE OF BIRTH: <b>LETESEN</b>
GENDER: <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CIVIL STATUS: <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	NATIONALITY: <b>FILIPINO</b>
ADDRESS: <b>Bula, Letesen</b>		
PASSPORT NUMBER: <b>1234567890</b>		country of destination: <b>JAPAN</b>
POSITION APPLIED FOR: <b>DECK CREW</b>		

SATISFACTORY HEARING?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
SATISFACTORY SIGHT?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
SATISFACTORY COLOR VISION? (WHEN REQUIRED)	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
SATISFACTORY PSYCHOLOGICAL TEST?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

IS APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY LANDBASED OVERSEAS WORK OR TO RENDER THE APPLICANT UNFIT FOR SUCH SERVICE OR TO ENDANGER THE HEALTH OF OTHER PERSONS?

YES  NO

PHOTO (MUG SHOT)	THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO: <b>SHANE CRUZ</b> (NAME OF APPLICANT)
OFFICIAL STAMP	RESULT: <input checked="" type="checkbox"/> FIT <input type="checkbox"/> UNFIT
Approved by: <b>Rogelio amando</b> Medical Director	

I HAVE READ AND UNDERSTOOD THE CONTENTS OF THE ABOVE AND THE INTEGRAL NOTES HEREOF.  
APPLICANT'S NAME AND SIGNATURE: **Shane Cruz** DATE: **01-03-2023**  
(THIS SIGNATURE SHOULD BE APPLIED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

DATE OF ISSUANCE OF PEME CERTIFICATE:  
(Filling out this field is not mandatory.)

DAY **03** MONTH **10** YEAR **2023**

DOH-PMEB-LB  
Rev.01-00  
05/21/2013

ANNEX - C  
A.O. No. 2013-0006  
NAME OF CLINIC  
DOH ACCREDITATION NUMBER  
Clinic Address  
Clinic Contact Information  
Email Address  
MEDICAL CERTIFICATE FOR LANDBASED OVERSEAS WORKERS  
Approved and authorized by the Department of Health (DOH)  
SURNAME/LAST NAME:

GIVEN NAME:

MIDDLE NAME

CRUZ

SHANE

C

AGE:

36

DAY

MONTH

YEAR

letesan

FILIPINO

GENDER:

MALE

FEMALE

CIVIL STATUS: SINGLE

MARRIED

RELIGION:

ADDRESS:

Bula, Letesen

PASSPORT NUMBER: 123456789

COUNTRY OF DESTINATION:

Japan

POSITION APPLIED FOR:

EMPLOYER/COMPANY/RECRUITMENT AGENCY (IF APPLICABLE):

DECK CREW

SATISFACTORY HEARING?

YES

NO

SATISFACTORY SIGHT?

YES

NO

SATISFACTORY COLOR VISION? (WHEN REQUIRED)

YES

NO

SATISFACTORY PSYCHOLOGICAL TEST?

YES

NO

IS APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY LANDBASED OVERSEAS WORK OR TO RENDER THE APPLICANT UNFIT FOR SUCH SERVICE OR TO ENDANGER THE HEALTH OF OTHER PERSONS?

YES

NO

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

PHOTO

SHANE CRUZ  
(NAME OF APPLICANT)

(MUG SHOT)

RESULT:

FIT

UNFIT

Name and Signature Physician

Marie E of Examining/ Authorized

Date of Examination:

SCP.29,2023

OFFICIAL STAMP

Approved

Director by: Rogelio

amando

Medical

I HAVE READ AND UNDERSTOOD THE CONTENTS OF THE ABOVE AND THE INTEGRAL NOTES HEREOF.

DATE: 09.03.2023

APPLICANT'S NAME AND SIGNATURE:

(The signature should be affixed in the presence of the examining physician)

Page of 2

**NAME OF CLINIC**  
DOH ACCREDITATION NUMBER  
Clinic Address  
Clinic Contact Information  
Email Address

MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS																																																																												
Approved and authorized by the Department Of Health (DOH)																																																																												
SURNAME/LAST NAME:	CRUZ	GIVEN NAME:	WENCEN	MIDDLE NAME:	C																																																																							
AGE:	36	DATE OF BIRTH:	01/01/1973	PLACE OF BIRTH:	GENSAN CITY, PHILIPPINES																																																																							
GENDER:	MALE	<input type="checkbox"/> FEMALE	<input checked="" type="checkbox"/> SINGLED	<input type="checkbox"/> MARRIED	<input type="checkbox"/> RELIGION: CATHOLIC																																																																							
ADDRESS:	BULIA, WENCAN																																																																											
PASSPORT NUMBER:	VJ14154789																																																																											
POSITION APPLIED FOR:	DECK CREW																																																																											
COUNTRY OF DESTINATION: JAPAN																																																																												
NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE)																																																																												
1. 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.																																																																												
<table border="0"> <tr> <td>Head or Neck Injury:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Other Lung Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/> Gynaecological Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/></td> </tr> <tr> <td>Frequent Headaches:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> High Blood Pressure</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Kidney or Bladder Disease</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Frequent Diarrhea:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Disease/Vascular</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Back Injury/Joint Pain/</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Fainting Spells, Fits, Seizures or Other Neurological Disorders:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Rheumatic Fever</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Genetic, Hereditary or Familial Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Insomnia or Sleep Disorders:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Diabetes Mellitus</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/> Sexually Transmitted Diseases</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Depression, other Mental or Eye Problems/</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Other Endocrine Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/> Physical Diseases (e.g. Malaria, Typhoid Fever, etc.)</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Deafness, Other Ear Disorders:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Blood Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/> Schistosomiasis (Specify Date):</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/></td> </tr> <tr> <td>None or Threat Disorders:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Stomach Pain, Gastritis or Ulcer</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Asthma</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Tuberculosis:</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Other Abdominal Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input checked="" type="checkbox"/> Allergies (Specify):</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Operations(s) (Specify):</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> </table>						Head or Neck Injury:	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Other Lung Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/> Gynaecological 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"/> Kidney or Bladder Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Frequent Diarrhea:	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Disease/Vascular	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Back Injury/Joint Pain/	YES <input type="checkbox"/>	NO <input 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"/> Genetic, Hereditary or Familial Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Insomnia or Sleep Disorders:	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Diabetes Mellitus	YES <input type="checkbox"/>	NO <input type="checkbox"/> Sexually Transmitted Diseases	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Depression, other Mental or Eye Problems/	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Other Endocrine Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/> Physical Diseases (e.g. Malaria, Typhoid Fever, etc.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Deafness, Other Ear Disorders:	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Blood Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/> Schistosomiasis (Specify Date):	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	None or Threat 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 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 type="checkbox"/>						Operations(s) (Specify):	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Head or Neck Injury:	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Other Lung Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/> Gynaecological 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"/> Kidney or Bladder Disease	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																						
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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"/> Genetic, Hereditary or Familial Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																						
Insomnia or Sleep Disorders:	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/> Diabetes Mellitus	YES <input type="checkbox"/>	NO <input type="checkbox"/> Sexually Transmitted Diseases	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																						
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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 type="checkbox"/>																																																																						
					Operations(s) (Specify):	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																					
Place a check mark (✓) in the appropriate box.																																																																												
1. Have you ever been signed off as sick or repatriated from a jobsite overseas? 2. Have you ever been declared unfit for work overseas? 3. Have you ever been declared unfit for work overseas? 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/occupation? 7. Are you allergic to any medication? Comments: _____  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 dosage(s): DON-PEMER-LA Reserves 00 06/21/2013 Page 102																																																																												
2. Have you ever been signed off as sick or repatriated from a jobsite overseas?																																																																												
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Place a check mark () in the appropriate box																																																																												
YES <input type="checkbox"/> NO <input type="checkbox"/> 1. Have you ever been signed off as sick or repatriated from a jobsite overseas? 2. Have you ever been hospitalized? 3. Have you ever been declared unfit for work overseas?																																																																												

INTEGRAL NOTES  
ANNEX C  
A.O. No. 2013-006

**NAME OF CLINIC**  
DOH ACCREDITATION NUMBER  
Clinic Address  
Clinic Contact Information  
Email Address

**MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS**  
Approved and authorized by the Department Of Health (DOH)

**SURNAME/LAST NAME:** CRUZ **GIVEN NAME:** WENCEN **MIDDLE NAME:** C

**AGE:** 36 **DATE OF BIRTH:** 01/01/1973 **PLACE OF BIRTH:** GEN SAN CITY, PHILIPPINES **NATIONALITY:** PHILIPPINES

**GENDER:** MALE  **FEMALE** **CIVIL STATUS:** SINGLED **RELIGION:** CATHOLIC

**ADDRESS:** BULIA, WENCAN

**PASSPORT NUMBER:** VJ14154789 **COUNTRY OF DESTINATION:** JAPAN

**POSITION APPLIED FOR:** DECK CREW

**NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE)**

**1. 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  NO  Other Lung Disorders  
YES  NO  Gynaecological Disorders  
YES  NO  High Blood Pressure  
YES  NO  Last Menstrual Period  
YES  NO  Frequent Dizziness  
YES  NO  Heart Disease/Vascular/  
36 DAY MONTH YEAR GENSAN CITY PHIL COUNTRY HUING GENDER: MALE FEMALE CIVIL STATUS: SINGLE MARRIED RELIGION: CATHOLIC ADDRESS: BULIA, wencan PASSPORT NUMBER: VJ14154789 COUNTRY OF DESTINATION: JAPAN POSITION APPLIED FOR: DECK CREW APPLICABLE:

**1. 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

**Comments:** \_\_\_\_\_

**2. Have you ever been signed off as sick or repatriated from a jobsite overseas?**  
**3. Have you ever been hospitalized?**  
**4. Do you feel healthy and fit to perform the duties of your designated position/occupation?**  
**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/occupation?**  
**7. Are you allergic to any medication?**  
**Comments:** \_\_\_\_\_

**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 dosage(s):  
DON-PEMER-LA  
Reserves 00  
06/21/2013  
Page 102

**YES**  
**NO**

**1. Have you ever been signed off as sick or repatriated from a jobsite overseas?**  
**2. Have you ever been hospitalized?**  
**3. Have you ever been declared unfit for work overseas?**

**II. MEDICAL EXAMINATION**  
Enter the date called for. Place a check mark (✓) in the appropriate box □. Alongside columns A, B, & C, put a check mark (✓) under YES if Normal, if (when required) or inadequate.

WEIGHT (kg)	WEIGHT (kg)	BLOOD PRESSURE (mm Hg)	PULSE RATE (min)	RESPIRATION (res./min)	SKIN
105	105	Systolic: 120 Diastolic: 80	72	16	
VISION ACUITY		NEAR VISION		SHIMMARA COLOR VISION (when required)	
Uncorrected: OD 20/ (05 20) OS 20/ (05 20)		Corrected: OD 20/ (05 20) OS 20/ (05 20)		Bar (Hearing) (Conversational or by Auditory when required)	
				CLARITY OF SPEECH	
Defective		Adequate		Right Adequate Left Inadequate	
Corrected		Defective		Inadequate	

A	YES	Significant Findings	B	YES	Significant Findings	C	YES	Significant Findings
Skin	<input checked="" type="checkbox"/>	Neck, Lymph Nodes, Thyroid	Chest-Breast-Axilla	<input type="checkbox"/>	Genito-urinary System	Extremities	<input type="checkbox"/>	
Head, neck, scalp	<input checked="" type="checkbox"/>	Chest-Breast-Axilla	Lungs	<input type="checkbox"/>	Genitals	Reflexes	<input type="checkbox"/>	
Eyes, external	<input checked="" type="checkbox"/>	Lungs	Heart	<input type="checkbox"/>	Dental	(Teeth/Gums)	<input type="checkbox"/>	
Post, Ophthalmoscopic	<input checked="" type="checkbox"/>	Heart	Abdomen	<input type="checkbox"/>			<input type="checkbox"/>	
Ears	<input checked="" type="checkbox"/>	Abdomen		<input type="checkbox"/>			<input type="checkbox"/>	
Nose, Sinuses	<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>	
Mouth, Throat	<input checked="" type="checkbox"/>		Anus-rectum	<input type="checkbox"/>			<input type="checkbox"/>	

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

A. CHEST X-RAY:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> With Findings	G. HIV/AIDS Test:	<input type="checkbox"/> Reactive	<input checked="" type="checkbox"/> Non-Reactive
B. ECG:	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> With Findings	H. RPR and/or:	<input type="checkbox"/> Reactive	<input checked="" type="checkbox"/> Non-Reactive
(for 240 yds)			I. STOOL EXAM:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> With Findings
C. CBC:	<input type="checkbox"/> Normal	<input checked="" type="checkbox"/> With Findings	J. Hepatitis B:	<input type="checkbox"/> Reactive	<input checked="" type="checkbox"/> Non-Reactive
			K. Hepatitis C:	<input type="checkbox"/> Reactive	<input checked="" type="checkbox"/> Non-Reactive
			L. BLOOD TYPE (Specify):	O+	

**PSYCHOLOGICAL TEST:**  Normal  For Further Evaluation

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

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

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

**V. ASSESSMENT OF FITNESS FOR LANDBASED OVERSEAS WORK.** 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:

RT	UNIT	<input type="checkbox"/>
DATE OF MEDICAL EXAMINATION:	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: (Filling out this field is not mandatory.)	MEDICAL EXAMINATION REPORT NO:
29 DAY	MONTH	YEAR
NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: SARAH MENDEZ		
LICENSE NUMBER: ABC CLINIC		
ADDRESS: 1234 PEPPER ST. 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, POEA, my employer and (Name of Clinic) ABC CLINIC		
NAME AND SIGNATURE OF APPLICANT: OCT. 03, 2023		
THIS SIGNATURE SHOULD BE AFRICIO X PRESENCE OF THE EXAMINING PHYSICIAN		
DATE: OCT. 03, 2023		
NAME AND SIGNATURE OF APPLICANT: DON-PEMERLA		
THIS SIGNATURE SHOULD BE AFRICIO X PRESENCE OF THE EXAMINING PHYSICIAN		
REVISION 00		
06/21/2013		
Page 202		

Reactive  
(when required)  
Non-Reactive  
TPHA – 40 y/o)  
TPHA  
C CBC:  
Normal  
With Findings  
F. Hepatitis B:  
Reactive  
Non-Reactive  
E. BLOOD TYPE (Specify):  
(when required)  
of  
PSYCHOLOGICAL TEST:  
Normal  
For Further Evaluation

ADDITIONAL TEST(S) (Specify): es Blood Chemistries, Drug Test, Alcohol  
Test, Liver Function Test, Stool Culture, etc.  
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  
PSSSSES:

NON-SIGNIFICANT FINDINGS  
Host Country Medical and Laboratory Requirements:

V. ASSESSMENT OF FITNESS FOR LANDBASED OVERSEAS WORK. 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:

NOT DEFECTIVE  
FIT

DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT:  
MEDICAL EXAMINATION REPORT

DATE OF MEDICAL EXAMINATION:  
(Filling out this field is not mandatory.)

NO:  
29  
DAY  
MONTH  
YEAR  
DAY  
MONTH  
YEAR

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: Sarah MENDEZ

LICENSE NUMBER:

BRUNN NORTH City

9687

INTEGRAL NOTES

ANNEX - C

A.O. No. 2013-0006

II. MEDICAL EXAMINATION

Enter the date called for. Place a check mark (✓) in the appropriate box □. Alongside columns A, B, & C, put a check mark (✓) under YES if Normal, if (when required) or inadequate.

Alongside columns A, B, & C, put a check mark (✓) under YES if Normal, if (when required) or inadequate.

Uncorrected

OD 20/ (05 20) OS 20/ (05 20)

Adequate

Right Adequate Left Inadequate

Corrected

OD 20/ (05 20)

Inadequate

Defective

Left Inadequate

Right Defective

Left Inadequate

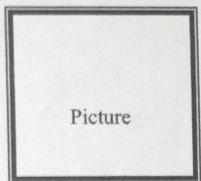
ANNEX - I  
A.O. No. 2013-0006

NAME OF CLINIC

Address  
Contact Information  
E-mail address

HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING  
TEST CERTIFICATE

This is to certify that Mr./Ms. Shane Cruz  
has undergone screening test for HIV/Acquired Immunodeficiency Syndrome (AIDS), and was found to  
be Non-Reactive\*/Reactive\* based on laboratory test (HIV-1/HIV-2).



Picture

12a M

Examining Physician  
License No. 123  
Date of Medical Examination 09/30/23

LABORATORY REPORT

Date: OCT. 03, 2023

Name: Shane CRUZ Age: 36 Sex: F Civil Status: MARIED  
Address: Bula, letnacan CITY

Human Immunodeficiency Virus Types I (HIV-I) and (HIV-2) as a screening test for HIV/AIDS:

Screening Test Used: (please check)

- RAPID
- Particle Agglutination
- EIA / CMIA / ELFA
- Others (specify) \_\_\_\_\_

RESULT \*

NONREACTIVE

REACTIVE

Medical Technologist  
HIV Proficiency Cert. No. 4520  
Expiry date \_\_\_\_\_

Pathologist  
ZYDNE TEPARE

\*A non-reactive result indicates that the tested sample does not contain detectable Human Immunodeficiency Virus (HIV) antibody. This does not preclude the possibility of recent exposure to an infection by HIV.

MFOWS-Annex I-HIVST  
Revision:01  
06/08/2011

ANNEX - I  
A.O. No. 2013-0006  
NAME OF CLINIC  
Address  
Contact Information  
E-mail address  
HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING  
TEST CERTIFICATE  
This is to certify that Mr./Ms.  
Shane Cruz  
has undergone screening test for HIV/Acquired Immunodeficiency Syndrome (AIDS), and was found to  
be Non-Reactive\*/Reactive\* based on laboratory test (HIV-1/HIV-2).  
uza M  
Examining Physician  
License No. 123  
Picture  
Date of Medical Examination 09/30/23  
LABORATORY REPORT  
Date: OCT.03,2023  
Name: STERE CRUZ  
Age: 36 Sex: F  
Civil Status: SINCELE  
Address: Bula, letnacan CITY  
Human Immunodeficiency Virus Types I (HIV-I) and (HIV-2) as a screening  
test for HIV/AIDS:  
Screening Test Used: (please check)  
RAPID  
Particle Agglutination  
EIA / CMIA / ELFA  
Others (specify)  
RESULT \*  
NONREACTIVE  
REACTIVE  
PARKS  
Medical Technologist  
HIV Proficiency Cert. No. 456  
Expiry date  
Pathology  
\*A non-reactive result indicates that the tested sample does not contain  
detectable Human Immunodeficiency Virus (HIV) antibody. This does not  
preclude  
the possibility of recent exposure to an infection by HIV.  
MFOWS-Annex I-HIVST  
Revision:01  
06/08/2011

NAME OF CLINIC	
DOH ACCREDITATION NUMBER	
Clinic Address	
Clinic Contact Information	
Email Address	

INTEGRAL NOTES  
ANNEX-D  
A.O. No. 2013-0056

PASSPORT SIZE  
PHOTO

**MEDICAL EXAMINATION REPORT FOR SEAFARERS**

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

SURNAME/LAST NAME: <b>CROZ</b>	GIVEN NAME: <b>SHANE</b>	MIDDLE NAME: <b>C</b>																																																																																				
AGE: <b>36</b>	DATE OF BIRTH: <b>12/12/1977</b>	PLACE OF BIRTH: <b>MANILA, PHILIPPINES</b>																																																																																				
GENDER: <b>MALE</b>	DAY MONTH YEAR: <b>12/12/1977</b>	NATIONALITY: <b>PHILIPPINO</b>																																																																																				
POSITION APPLIED FOR: <b>DECK</b>	CIVIL STATUS: <b>SINGLE</b>	MARRIED: <b>NO</b>																																																																																				
RELIGION: <b>CATHOLIC</b>																																																																																						
ADDRESS: <b>BUA, LUNGSOD</b>																																																																																						
PASSPORT NUMBER: <b>1234567890</b>																																																																																						
SEAMAN'S BOOK NUMBER: <b>1234567890</b>																																																																																						
POSITION APPLIED FOR: <b>DECK</b> <input type="checkbox"/> ENGINE: <input type="checkbox"/> CATERING: <input type="checkbox"/> OTHERS: <input type="checkbox"/> (Specify)																																																																																						
NAME OF COMPANY:																																																																																						
I. MEDICAL HISTORY - Has applicant suffered from been diagnosed, sought advice or treatment from a medical doctor on the following condition: Place a check mark (✓) in the appropriate box.																																																																																						
<table border="1"> <tr> <td>Head or Neck Injury</td> <td>YES <input type="checkbox"/></td> <td>Other Lung Disorders</td> <td>YES <input type="checkbox"/></td> <td>Gynaecological Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Frequency</td> <td>YES <input type="checkbox"/></td> <td>Hip/Bone Pressure</td> <td>YES <input type="checkbox"/></td> <td>Menstrual Period, specify date</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Diabetes</td> <td>YES <input type="checkbox"/></td> <td>Heart Disease/Vascular</td> <td>YES <input type="checkbox"/></td> <td>Kidney or Bladder Disorder</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Fainting, Fainting, fits, Seizures</td> <td>YES <input type="checkbox"/></td> <td>Chest Pain</td> <td>YES <input type="checkbox"/></td> <td>Arthritis</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Insomnia or Sleep Disorders</td> <td>YES <input type="checkbox"/></td> <td>Rheumatic Fever</td> <td>YES <input type="checkbox"/></td> <td>Hand Injury/Joint Pain/Arthritis</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Depression, other Mental Disorders</td> <td>YES <input type="checkbox"/></td> <td>Diabetes Mellitus</td> <td>YES <input type="checkbox"/></td> <td>Facial Disorders</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Error of Refraction</td> <td>YES <input type="checkbox"/></td> <td>Other Endocrine Disorders</td> <td>YES <input type="checkbox"/></td> <td>Sexually Transmitted Diseases</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Deafness, Other Ear Disorders</td> <td>YES <input type="checkbox"/></td> <td>Cancer or Tumor</td> <td>YES <input type="checkbox"/></td> <td>Tropical Diseases (e.g. Malaria)</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Nose or Throat Disorders</td> <td>YES <input type="checkbox"/></td> <td>Blood Disorders</td> <td>YES <input type="checkbox"/></td> <td>Exophytic Fever, specify date: _____</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>Tuberculosis</td> <td>YES <input type="checkbox"/></td> <td>Stomach Pain, Gastritis</td> <td>YES <input type="checkbox"/></td> <td>Specify date: _____</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td colspan="3"></td> <td>Alcohol</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> <td></td> </tr> <tr> <td colspan="3"></td> <td>Allergies</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> <td>(Specify)</td> </tr> </table>			Head or Neck Injury	YES <input type="checkbox"/>	Other Lung Disorders	YES <input type="checkbox"/>	Gynaecological Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Frequency	YES <input type="checkbox"/>	Hip/Bone Pressure	YES <input type="checkbox"/>	Menstrual Period, specify date	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Diabetes	YES <input type="checkbox"/>	Heart Disease/Vascular	YES <input type="checkbox"/>	Kidney or Bladder Disorder	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Fainting, Fainting, fits, Seizures	YES <input type="checkbox"/>	Chest Pain	YES <input type="checkbox"/>	Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Insomnia or Sleep Disorders	YES <input type="checkbox"/>	Rheumatic Fever	YES <input type="checkbox"/>	Hand Injury/Joint Pain/Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Depression, other Mental Disorders	YES <input type="checkbox"/>	Diabetes Mellitus	YES <input type="checkbox"/>	Facial Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Error of Refraction	YES <input type="checkbox"/>	Other Endocrine Disorders	YES <input type="checkbox"/>	Sexually Transmitted Diseases	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Deafness, Other Ear Disorders	YES <input type="checkbox"/>	Cancer or Tumor	YES <input type="checkbox"/>	Tropical Diseases (e.g. Malaria)	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Nose or Throat Disorders	YES <input type="checkbox"/>	Blood Disorders	YES <input type="checkbox"/>	Exophytic Fever, specify date: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Tuberculosis	YES <input type="checkbox"/>	Stomach Pain, Gastritis	YES <input type="checkbox"/>	Specify date: _____	YES <input type="checkbox"/>	NO <input type="checkbox"/>				Alcohol	YES <input type="checkbox"/>	NO <input type="checkbox"/>					Allergies	YES <input type="checkbox"/>	NO <input type="checkbox"/>	(Specify)
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			Allergies	YES <input type="checkbox"/>	NO <input type="checkbox"/>	(Specify)																																																																																
Previous Hospitalization(s)/ Operation(s). Place a check mark () in the appropriate box																																																																																						
<table border="1"> <tr> <td>1. Have you ever been signed off as sick or repatriated from a ship?</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>2. Are you allergic to any medication?</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>3. Have you ever been declared unfit for sea duty?</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>4. Has your medical certificate ever been restricted or revoked?</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>5. Are you aware that you have any medical problem, disease or illness?</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>6. Do you feel healthy and fit to perform the duties of your designated position/occupation?</td> <td>YES <input type="checkbox"/></td> <td>NO <input type="checkbox"/></td> </tr> <tr> <td>7. Are you allergic to any medication?</td> <td>Comments</td> <td></td> </tr> <tr> <td colspan="3">If yes, please let the medication(s) taken/being taken, and the purpose(s) and dosage(s)</td> </tr> </table>			1. Have you ever been signed off as sick or repatriated from a ship?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	2. Are you allergic to any medication?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	3. Have you ever been declared unfit for sea duty?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	4. Has your medical certificate ever been restricted or revoked?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	5. Are you aware that you have any medical problem, disease or illness?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	6. Do you feel healthy and fit to perform the duties of your designated position/occupation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	7. Are you allergic to any medication?	Comments		If yes, please let the medication(s) taken/being taken, and the purpose(s) and dosage(s)																																																														
1. Have you ever been signed off as sick or repatriated from a ship?	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																																				
2. Are you allergic to any medication?	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																																				
3. Have you ever been declared unfit for sea duty?	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																																				
4. Has your medical certificate ever been restricted or revoked?	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																																				
5. Are you aware that you have any medical problem, disease or illness?	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																																				
6. Do you feel healthy and fit to perform the duties of your designated position/occupation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>																																																																																				
7. Are you allergic to any medication?	Comments																																																																																					
If yes, please let the medication(s) taken/being taken, and the purpose(s) and dosage(s)																																																																																						
B. MEDICAL EXAMINATION																																																																																						
Enter the data called for. Place a check mark (✓) in the appropriate box																																																																																						
HEIGHT: <b>175</b>	WEIGHT (kg): <b>70</b>	BLOOD PRESSURE: <b>120/80 (mm Hg)</b>	PULSE RATE: <b>70/min</b>	RESPIRATION: <b>16/min</b>	BMI: <b>24</b>																																																																																	
VISION:	FAIR VISION NEAR VISION	ISHIHARA COLOR VISION	EAR: Hearing by Audiometry	CLARITY OF SPEECH																																																																																		
Uncorrected: <b>OD 20/20 OS 20/20</b>	Corrected: <b>OD 20/20 OS 20/20</b>	Adequate: <input type="checkbox"/> Right: <input type="checkbox"/> Adequate: <input type="checkbox"/> Inadequate: <input type="checkbox"/> Adequate: <input type="checkbox"/>	Defective: <input type="checkbox"/> Left: <input type="checkbox"/> Adequate: <input type="checkbox"/> Inadequate: <input type="checkbox"/> Defective: <input type="checkbox"/>																																																																																			
ENTER THE DATA CALLED FOR. PLACE A CHECK MARK (✓) IN THE APPROPRIATE BOX																																																																																						
Page 1 of 2																																																																																						

INTEGRAL NOTES  
ANNEX-D  
NAME OF CLINIC  
A.O. No. 2013-0056  
DOH ACCREDITATION NUMBER  
Clinic Address  
Clinic Contact Information  
PASSPORT SIZE  
Email Address  
PHOTO

**MEDICAL EXAMINATION REPORT FOR SEAFARERS**

Approved and authorized by the Department of Health (DOH) and the Maritime Industry Authority (MAA/NA) 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

SURNAMES/LAST NAME: **CROZ**

GIVEN NAME: **SHANE**

MIDDLE NAME: **C**

AGE: **36**

DATE OF BIRTH: **12/12/1977**

PLACE OF BIRTH: **MANILA, PHILIPPINES**

NATIONALITY: **PHILIPPINO**

POSITION APPLIED FOR: **DECK**

SEX: **MALE**

RELATIONSHIP: **Single**

RELIGION: **CATHOLIC**

ADDRESS: **BUA, LUNGSOD**

PASSPORT NUMBER: **1234567890**

SEAMAN'S BOOK NUMBER: **1234567890**

POSITION APPLIED FOR: **DECK**  ENGINE:  CATERING:  OTHERS:  (Specify)

NAME OF COMPANY:

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  Other Lung Disorders YES  NO  Gynaecological Disorders YES  NO   
Frequency YES  NO  High Blood Pressure YES  NO  Menstrual Period, specify date YES  NO   
Diabetes YES  NO  Heart Disease/Vascular YES  NO  Chest Pain YES  NO   
Insomnia or Sleep Disorders YES  NO  Arthritis YES  NO  Hand Injury/Joint Pain/Arthritis YES  NO   
Depression, other Mental Disorders YES  NO  Diabetes Mellitus YES  NO  Facial Disorders YES  NO   
Error of Refraction YES  NO  Other Endocrine Disorders YES  NO  Sexually Transmitted Diseases YES  NO   
Deafness, Other Ear Disorders YES  NO  Cancer or Tumor YES  NO  Tropical Diseases (e.g. Malaria) YES  NO   
Nose or Throat Disorders YES  NO  Blood Disorders YES  NO  Exophytic Fever, specify date: \_\_\_\_\_ YES  NO   
Tuberculosis YES  NO  Stomach Pain, Gastritis YES  NO  Specify date: \_\_\_\_\_ YES  NO   
Other Abdominal Disorders YES  NO  Allergies YES  NO  (Specify)

Previous Hospitalization(s)/ Operation(s).  
Place a check mark () in the appropriate box

1. Have you ever been signed off as sick or repatriated from a ship? YES  NO   
2. Are you allergic to any medication? YES  NO   
3. Have you ever been declared unfit for sea duty? YES  NO   
4. Has your medical certificate ever been restricted or revoked? YES  NO   
5. Are you aware that you have any medical problem, disease or illness? YES  NO   
6. Do you feel healthy and fit to perform the duties of your designated position/occupation? YES  NO   
7. Are you allergic to any medication? Comments \_\_\_\_\_

If yes, please let the medication(s) taken/being taken, and the purpose(s) and dosage(s)

B. MEDICAL EXAMINATION

Enter the data called for. Place a check mark (✓) in the appropriate box

HEIGHT: **175**

WEIGHT (kg): **70**

BLOOD PRESSURE: **120/80 (mm Hg)**

PULSE RATE: **70/min**

RESPIRATION: **16/min**

VISION:

FAIR VISION NEAR VISION

ISHIHARA COLOR VISION

EAR: Hearing by Audiometry

CLARITY OF SPEECH

Uncorrected: **OD 20/20 OS 20/20**

Corrected: **OD 20/20 OS 20/20**

Adequate:  Right:  Adequate:  Inadequate:  Adequate:   
Defective:  Left:  Adequate:  Inadequate:  Defective:

ENTER THE DATA CALLED FOR. PLACE A CHECK MARK (✓) IN THE APPROPRIATE BOX

Page 2 of 2

NO Disorders  
YES  
NO

(e.g. Golter)  
Tropical Diseases (e.g. Malana, YES

NO

Eye Problems/  
Error of Refraction  
YES  
NO

Cancer or Tumor  
YES  
NO

Typhoid Fever, specify date)  
Deafness, Other Ear Disorders  
YES  
NO

Blood Disorders  
YES  
NO

Schistosomiasis  
YES  
NO

(Specify date:  
)

Nose or Throat Disorders  
YES  
NO

Stomach Pain, Gastritis  
YES  
NO

Asthma  
YES  
NO

Stomach Ulcer  
Tuberculosis  
YES  
NO

Other Abdominal Disorders  
YES  
NO

Allergies  
YES  
NO

(Specify.)

Previous Hospitalization(s) / Operation(s).  
Place a check mark () in the appropriate box

YES  
NO

I.  
Have you ever been signed off as sick or repatriated from a ship?  
YES  
NO

OD 20/  
OS 20/  
Corrected  
OD 20/  
OS 20/  
OD 20/  
OSJ  
Defective  
Left  
Adequate  
Inadequate  
Defective  
DOH-MER-SS  
Revision: 03  
10/17/2013  
Page 2

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 type="checkbox"/>		Neck, Lymph Nodes, Thyroid	<input checked="" type="checkbox"/>		Gastro-urinary System	<input type="checkbox"/>	
Head, neck, scalp	<input checked="" type="checkbox"/>		Chest-Breast-Axilla	<input checked="" type="checkbox"/>		Extremities	<input checked="" type="checkbox"/>	
Eyes, external	<input checked="" type="checkbox"/>		Lungs	<input checked="" type="checkbox"/>		Reflexes	<input checked="" type="checkbox"/>	
Pupils	<input checked="" type="checkbox"/>		Heart	<input checked="" type="checkbox"/>		Dental (Teeth/Gums)	<input checked="" type="checkbox"/>	
Ophthalmoscopic	<input checked="" type="checkbox"/>		Abdomen	<input checked="" type="checkbox"/>				
Ears	<input checked="" type="checkbox"/>		Back	<input checked="" type="checkbox"/>				
Nose, Sinuses	<input checked="" type="checkbox"/>		Anus-rectum	<input checked="" type="checkbox"/>				
Mouth, Throat	<input checked="" type="checkbox"/>							

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

A. CHEST X-RAY	<input 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 type="checkbox"/> Non-Reactive
B. ECG	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> With Findings	E. STOOL EXAM.	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> With Findings	H. Blood and/or Urine Tests	<input type="checkbox"/> Reactive	<input type="checkbox"/> Non-Reactive
C. CBC	<input type="checkbox"/> Normal	<input type="checkbox"/> With Findings	F. Hepatitis B:	<input checked="" type="checkbox"/> Reactive	<input type="checkbox"/> Non-Reactive	I. BLOOD TYPE (Specify):	OT	

PSYCHOLOGICAL TEST (when required):  For Further Evaluation

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

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 Medical and Laboratory Requirements	<input checked="" type="checkbox"/> PASSED	<input type="checkbox"/> WITH SIGNIFICANT FINDINGS

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

DECK SERVICE	<input checked="" type="checkbox"/>	ENGINE SERVICE	<input checked="" type="checkbox"/>	CATERING SERVICE	<input checked="" type="checkbox"/>	OTHER SERVICES	<input checked="" type="checkbox"/>
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WITH RESTRICTIONS:  WITHOUT RESTRICTIONS:   
 Describe restrictions\*\* (refer to standard restrictions at the bottom of this page).

DATE OF MEDICAL EXAMINATION: 09 DAY 29 MONTH 2023 YEAR: 2023 MEDICAL EXAMINATION REPORT NO: 82016

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: LEG. *[Signature]* ADDRESS: wencan

NAME AND SIGNATURE OF SEAFARER: *[Signature]* DATE: 09.03.2023

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

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  
 D. YES  
 Significant Findings  
 E. YES  
 Significant Findings  
 F. YES  
 Significant Findings  
 G. YES  
 Significant Findings  
 H. YES  
 Significant Findings  
 I. YES  
 Significant Findings  
 J. YES  
 Significant Findings  
 K. YES  
 Significant Findings  
 L. YES  
 Significant Findings  
 M. YES  
 Significant Findings  
 N. YES  
 Significant Findings  
 O. YES  
 Significant Findings  
 P. YES  
 Significant Findings  
 Q. YES  
 Significant Findings  
 R. YES  
 Significant Findings  
 S. YES  
 Significant Findings  
 T. YES  
 Significant Findings  
 U. YES  
 Significant Findings  
 V. YES  
 Significant Findings  
 W. YES  
 Significant Findings  
 X. YES  
 Significant Findings  
 Y. YES  
 Significant Findings  
 Z. YES  
 Significant Findings  
 AA. YES  
 Significant Findings  
 BB. YES  
 Significant Findings  
 CC. YES  
 Significant Findings  
 DD. YES  
 Significant Findings  
 EE. YES  
 Significant Findings  
 FF. YES  
 Significant Findings  
 GG. YES  
 Significant Findings  
 HH. YES  
 Significant Findings  
 II. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (✓) in the appropriate box.

With Findings  
 H RPR and/or Reactive  
 Non-Reactive  
 TPPA  
 C CBC: Normal  
 With Findings  
 F. Hepatitis B: Reactive  
 Non-Reactive  
 I BLOOD TYPE (Specify): of (when required)  
 PSYCHOLOGICAL TEST (when required):  
 Normal  
 For Further Evaluation  
 ADDITIONAL TEST(S) (Specify). e.g. Blood Chemistries, Drug Test, Alcohol Test, Liver Function Test, Stool Culture, etc.  
 IV. SUMMARY. Place a check mark in the appropriate box  
 BASIC DOH MANDATORY MEDICAL EXAMINATION PASSED  
 WITH SIGNIFICANT FINDINGS Additional Laboratory Tests.  
 Flag/Host Medical and Laboratory Requirements PASSED  
 WITH SIGNIFICANT FINDINGS REMARKS/SPECIAL NEEDS (Specify e.g. with medication, diet restriction 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:  
 FIT FOR LOOK-OUT DUTY  
 NOT FIT FOR LOOK-OUT DUTY  
 DECK SERVICE  
 ENGINE SERVICE  
 CATERING SERVICE  
 OTHER SERVICES  
 FIT  
 UNIT  
 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: 09 DAY 29 MONTH 2023 YEAR: 2023  
 MEDICAL EXAMINATION REPORT NO:  
 09 DAY 29 MONTH 2023 YEAR  
 09.03.2023

29  
 DAY  
 03  
 MONTH  
 2023  
 YEAR  
 32015  
 NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN:  
 LICENSE NUMBER: 454789  
 ADDRESS: wencan

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 and the diagnostic test results recorded above.

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

OCT.03, 2023

NAME AND SIGNATURE OF SEAFARER

DATE

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

\*\*STANDARD RESTRICTIONS (Duties)

No sole watchkeeping  
 Not to work with (specify)  
 Not fit for emergency duties  
 Not fit for food handling  
 Not fit for lookout duties  
 Within (specify) miles from a safe haven  
 Only fit for lookout during daylight hours  
 Near coastal only  
 Not fit for work with colour coded tables etc  
 Coastal waters only, up to (specify) miles from shore  
 Non-travel waters only  
 Not to be away from (home) port for periods over 24 hours/7days  
 Not fit for service on stand-by vessels

Not to lift items weighing over 5/10/20/40kg  
 Fee for service only on vessels with ship's doctor  
 Protective gloves to be worn for work with (specify)  
 Cleaning/washing facilities in private cabin required

Eye protection to be worn for all work  
 Special needs in emergencies (specify)

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10/17/2013

Page of 2