

NO  
 Disorders  
 YES  
 NO  
 (e.g. Golter)  
 Tropical Diseases (e.g. Malana), YES  
 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  
 or 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  
 1.  
 Have you ever been signed off as sick or repatriated  
 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 Chemistry, 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"/> |
|--------------|-------------------------------------|----------------|-------------------------------------|------------------|-------------------------------------|----------------|-------------------------------------|

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: 82015

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 Chemistry, 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 solo watchkeeping  
 Not to work with (specify)  
 Not fit for emergency duties  
 Not fit for lookout duties  
 Not fit for work with colour coded tables etc  
 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/7days  
 Not to lift items weighing over 5/10/20/40kg  
 Protective gloves to be worn for work with (specify)  
 Eye protection to be worn for all work

Special needs in emergencies (specify)  
 DOH-PEMER-SB  
 Revision.00  
 I  
 10/17/2013  
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