



Certificate No- BSMC201966814H
GUIDELINES AND MINIMUM REQUIREMENTS FOR:

**PRE-SEA AND PERIODIC MEDICAL FITNESS EXAMINATIONS
OF SEAFARERS**

{ Merchant Shipping (Medical Examination) Rules 2000 ;
STCW code I/9 and MLC 2006 - Reg I.2 And
ILO/IMO Guidelines on the medical examinations of seafarers ILO/IMO/JMS/2511/12 } {

Family Name	GAWDE		
Given Names	MITESH SANJAY		
Rank and department	Deck Service		
Date of birth (day/month/year)	18-Aug-1993	Sex:	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Nationality	INDIAN		
Home address	ANTHONY CHAWL, UTTKARSH MANAR, DATTA MANDIR ROAD, VAKOLA PIPE LINE, SANTACRUZ (E) MUMBAI MUMBAI INDIA 400055		
Residence & Mobile No:	9664984602		
Passport No./Discharge Book No.:	Z5155646		
Type of ship (container, tanker, passenger, fishing)			
Trade area (e.g., coastal, tropical, worldwide)	W.W		

A. EXAMINEE'S PERSONAL DECLARATION

(Assistance should be offered by medical staff)

Have you ever had any of the following conditions?

Condition	Yes	No	Condition	Yes	No
1. Eye/vision problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	18. Sleep problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. High blood pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	19. Do you smoke; use alcohol or drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Heart/vascular disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	20. Operation/surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Heart surgery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	21. Epilepsy/seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Varicose veins	<input type="checkbox"/>	<input checked="" type="checkbox"/>	22. Dizziness/fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Asthma/bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	23. Loss of consciousness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Blood disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	24. Psychiatric problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	25. Depression	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Thyroid problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	26. Attempted suicide	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Digestive disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	27. Loss of memory	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Kidney problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	28. Balance problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Skin problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	29. Severe headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	30. Ear/nose/throat problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
14. Infectious/contagious diseases	<input type="checkbox"/>	<input checked="" type="checkbox"/>	31. Restricted mobility	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15. Hernia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	32. Back or joint problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>
16. Genital disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	33. Amputation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
17. Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	34. Fractures/dislocations	<input type="checkbox"/>	<input checked="" type="checkbox"/>

If any of the above questions were answered "yes", please give details.