

NAME OF CLINIC

DOH ACCREDITATION NUMBER

Clinic Address

Clinic Contact Information

Email Address

PASSPORT SIZE
PHOTO**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 the Maritime Labour Convention, 2006

SURNAME/LAST NAME: <u>Belmonte</u>		GIVEN NAME: <u>Jasmine</u>		MIDDLE NAME: <u>San Miguel</u>
AGE: <u>43</u>	DATE OF BIRTH: <u>00/10/1980</u> DAY MONTH YEAR	PLACE OF BIRTH: <u>Lipa</u> <u>Philippines</u> CITY COUNTRY	NATIONALITY: <u>Filipino</u>	
GENDER: MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	CIVIL STATUS: SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/>	RELIGION: <u>Christian</u>		
ADDRESS: <u>199 Anywhere St. Duplex Homes Subd. Talon IV Lipa City</u>				
PASSPORT NUMBER: <u>1234 789</u>		SEAMAN'S BOOK NUMBER: <u>66789</u>		
POSITION APPLIED FOR: DECK <input checked="" 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 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"/>	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"/>	Last Menstrual Period, specify date	<u>04/10/2022</u>
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 Diseases	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 checked="" 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 checked="" type="checkbox"/>	Schistosomiasis (Specify date: <u>02/10/2021</u>)	YES <input checked="" type="checkbox"/> NO <input 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 checked="" 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 <u>peanut, shrimp</u> (Specify)	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

Previous Hospitalization(s)/ Operation(s).

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?
- 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: Neozep, Alaxan, Memordin, Antinol, Biogesic, Mckon, Biogesic, Lymph, Simvastatin, Aabo, Sibuyac
- 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):
Mephramin, Red Pill, Blue Pill, Remid, C2, Vitamin C, Enervon

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 checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

II. MEDICAL EXAMINATIONEnter the data called for. Place a check mark (✓) in the appropriate box ☐.

HEIGHT (cm): <u>165</u>	WEIGHT (kg): <u>79</u>	BLOOD PRESSURE: Systolic: <u>120</u> (mm Hg) Diastolic: <u>70</u> (mm Hg)	PULSE RATE <u>90</u> /min RHYTHM: <u>Regular</u>	RESPIRATION: <u>16</u> /min	BMI: <u>28.1</u>
VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION	EAR	Hearing by Audiometry
Uncorrected	OD 20/20 OS 20/20	ODI 10/20 OSJ 20/20	Adequate <input checked="" type="checkbox"/>	Right	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
Corrected	OD 20/20 OS 20/20	ODI 40/40 OSJ 20/20	Defective <input type="checkbox"/>	Left	<input checked="" type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
				CLARITY OF SPEECH	
				Adequate <input checked="" type="checkbox"/>	
				Defective <input type="checkbox"/>	

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

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	D. URINALYSIS. <input type="checkbox"/> Normal <input checked="" type="checkbox"/> With Findings	G. HIV/AIDS Test. <input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Non-Reactive (when required)
B. ECG: <input type="checkbox"/> Normal <input checked="" type="checkbox"/> With Findings	E STOOL EXAM. <input type="checkbox"/> Normal <input checked="" type="checkbox"/> With Findings	H RPR and/or TPHA <input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Non-Reactive
C CBC: <input type="checkbox"/> Normal <input checked="" type="checkbox"/> With Findings	F. Hepatitis B: <input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Non-Reactive (when required)	I BLOOD TYPE (Specify): <u>B</u>

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	<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 LOOK-OUT DUTY <input checked="" type="checkbox"/>		NOT FIT FOR LOOK-OUT DUTY <input type="checkbox"/>	
FIT	DECK SERVICE <input checked="" type="checkbox"/>	ENGINE SERVICE <input checked="" type="checkbox"/>	CATERING SERVICE <input checked="" type="checkbox"/>
UNFIT	<input type="checkbox"/>	<input type="checkbox"/>	OTHER SERVICES <input checked="" type="checkbox"/>

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

Describe restrictions** (refer to standard restrictions at the bottom of this page).
No solo watchkeeping, Not fit emergency duty, Near coastal only, non-tropical waters only

DATE OF MEDICAL EXAMINATION: 16 / 10 / 2023 DAY MONTH YEAR	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: 16 / 10 / 2024 DAY MONTH YEAR	MEDICAL EXAMINATION REPORT NO: 474
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NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: Dr. Oliver Rodriguez
 LICENSE NUMBER: 987654
 ADDRESS: 187 Anywhere St. San Miguel Subd. Alabang Zapote Road Las Piñas City

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

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

Juagwin Boracho

NAME AND SIGNATURE OF SEAFARER

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

16 / 10 / 2023

DATE

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

- | | |
|---|---|
| <ul style="list-style-type: none"> • 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/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 | <ul style="list-style-type: none"> • 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 • Fit for service only on vessels with ship's doctor • Toilet/washing facilities in private cabin required • Special needs in emergencies (specify) |
|---|---|

