INTEGRAL NOTES
ANNEX – D
A.O. No. 2013-0006

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

SURNAME/LAST NAME: Caj	GIVEN NAME: Chris	MIDDLE NAME:
AGE: 30	DATE OF BIRTH: 07-07-1987 (DAY MONTH YEAR)	PLACE OF BIRTH: RC (CITY) PHL (COUNTRY)
GENDER: MALE ☑ FEMALE ☐	CIVIL STATUS: SINGLE ☑ MARRIED ☐	NATIONALITY: Filipino
		RELIGION: R.C.

ADDRESS: Address Chris 567

PASSPORT NUMBER: 123456789D	SEAMAN'S BOOK NUMBER: 123456789ABC

POSITION APPLIED FOR: DECK ☑ ENGINE ☐ CATERING ☐ OTHERS ☐ (Specify)_____

NAME OF COMPANY: Chris Shipping

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 ☐	NO ☑	Other Lung Disorders	YES ☐	NO ☑	Gynaecological Disorders	YES ☐	NO ☑
Frequent Headaches	YES ☐	NO ☑	High Blood Pressure	YES ☐	NO ☑	Last Menstrual Period, specify date _____		
Frequent Dizziness	YES ☐	NO ☑	Heart Disease/ Vascular/ Chest Pain	YES ☐	NO ☑	Kidney or Bladder Disorder	YES ☐	NO ☑
Fainting Spells, Fits, Seizures or Other Neurological Disorders	YES ☐	NO ☑	Rheumatic Fever	YES ☐	NO ☑	Back Injury/Joint Pain/ Arthritis	YES ☐	NO ☑
Insomnia or Sleep Disorders	YES ☐	NO ☑	Diabetes Mellitues	YES ☐	NO ☑	Genetic, Hereditary or Familial Disorders	YES ☐	NO ☑
Depression, other Mental Disorders	YES ☐	NO ☑	Other Endocrine Disorders (e.g. Goiter)	YES ☐	NO ☑	Sexually Transmitted Diseases	YES ☐	NO ☑
Eye Problems/ Error of Refraction	YES ☐	NO ☑	Cancer or Tumor	YES ☐	NO ☑	Tropical Diseases (e g. Malaria, Typhoid Fever, specify date)	YES ☐	NO ☑
Deafness, Other Ear Disorders	YES ☐	NO ☑	Blood Disorders	YES ☐	NO ☑	Schistosomiasis (Specify date: _____)	YES ☐	NO ☑
Nose or Throat Disorders	YES ☐	NO ☑	Stomach Pain, Gastritis or Ulcer	YES ☐	NO ☑	Asthma	YES ☐	NO ☑
Tuberculosis	YES ☐	NO ☑	Other Abdominal Disorders	YES ☐	NO ☑	Allergies (Specify._____)	YES ☐	NO ☑

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 from a ship?	☐	☑
2.	Have you ever been hospitalized?	☐	☑
3	Have you ever been declared unfit for sea duty?	☐	☑
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)	☐	☑

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

HEIGHT (cm). 178	WEIGHT (kg): 70	BLOOD PRESSURE: Systolic: 90 (mm Hg) Diastolic: 90 (mm Hg)	PULSE RATE 70 /min RHYTHM: _____	RESPIRATION: _____/min	BMI.

VISUAL ACUITY	FAR VISION 20	NEAR VISION 20	ISHIHARA COLOR VISION	EAR	Hearing by Audiometry		CLARITY OF SPEECH
Uncorrected	OD 20/ |OS 20/	ODJ | OSJ	Adequate ☐	Right	☐ Adequate	☐ Inadequate	Adequate ☐
Corrected	OD 20/ |OS 20/	ODJ | OSJ	Defective ☐	Left	☐ Adequate	☐ Inadequate	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	☐		Neck, Lymph Nodes, Thyroid	☐		Genito-urinary System	☐	
Head, neck, scalp	☐		Chest-Breast-Axilla	☐		Inguinals, Genitals	☐	
Eyes, external	☐		Lungs	☐		Extremities	☐	
Pupils, Ophthalmoscopic	☐		Heart	☐		Reflexes	☐	
Ears	☐		Abdomen	☐		Dental (Teeth/Gums)	☐	
Nose, Sinuses	☐		Back	☐				
Mouth, Throat	☐		Anus-rectum	☐				

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

A CHEST X-RAY ☑ Normal ☐ With Findings	D. URINALYSIS. ☑ Normal ☐ With Findings	G. HIV/AIDS Test. (when required) ☐ Reactive ☑ Non-Reactive
B. ECG: ☑ Normal ☐ With Findings	E STOOL EXAM. ☑ Normal ☐ With Findings	H RPR and/or TPHA ☐ Reactive ☑ Non-Reactive
C CBC: ☑ Normal ☐ With Findings	F. Hepatitis B: (when required) ☐ Reactive ☑ Non-Reactive	I BLOOD TYPE (Specify):

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.	☑ PASSED	☐ WITH SIGNIFICANT FINDINGS
Flag/Host Medical and Laboratory Requirements	☑ PASSED	☐ WITH SIGNIFICANT FINDINGS

REMARKS/SPECIAL NEEDS (Sspecify 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 ☑ **NOT FIT FOR LOOK-OUT DUTY** ☐

	DECK SERVICE	ENGINE SERVICE	CATERING SERVICE	OTHER SERVICES
FIT	☑	☑	☑	☑
UNFIT	☐	☐	☐	☐

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:	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT:	MEDICAL EXAMINATION REPORT NO:
05 (DAY) 07 (MONTH) 2023 (YEAR)	05 (DAY) 07 (MONTH) 2027 (YEAR)	1234567890

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: Physician 4
LICENSE NUMBER: 1234567890
ADDRESS: Physician 4 Address

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 (Chris Shipping).

Chris Ca

NAME AND SIGNATURE OF SEAFARER
THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

05-07-2023
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/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*
- *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)*