

## 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: <u>ERANA</u>		GIVEN NAME: <u>MARIE</u>		MIDDLE NAME: <u>CVASAT</u>	
AGE: <u>22</u>	DATE OF BIRTH: <u>02/06/2001</u> DAY MONTH YEAR		PLACE OF BIRTH: <u>DAGUPAN PH</u> CITY COUNTRY		NATIONALITY: <u>FILIPINO</u>
GENDER: MALE <input type="checkbox"/> FEMALE <input checked="" type="checkbox"/>	CIVIL STATUS: SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/>		RELIGION: <u>CATHOLIC</u>		
ADDRESS: <u>456 PALM AVE. BRGN. ROSARIO, CEBU CITY CEBU PHILIPPINES</u>					
PASSPORT NUMBER: <u>112233</u>			SEAMAN'S BOOK NUMBER: <u>777888</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: <u>SEAMANNING</u>					
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 <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 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>03/19/2002</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 type="checkbox"/> NO <input checked="" 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: _____)	YES <input type="checkbox"/> NO <input checked="" 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 type="checkbox"/> NO <input checked="" 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 checked="" type="checkbox"/>
Previous Hospitalization(s)/ Operation(s): _____					
Place a check mark (✓) in the appropriate box <input type="checkbox"/> .					
1. Have you ever been signed off as sick or repatriated from a ship?			YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	
2. Have you ever been hospitalized?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
3. Have you ever been declared unfit for sea duty?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
4. Has your medical certificate ever been restricted or revoked?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5. Are you aware that you have any medical problem, disease or illness?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
6. Do you feel healthy and fit to perform the duties of your designated position/occupation?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
7. Are you allergic to any medication?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Comments _____					
8. Are you taking any non-prescription or prescription medication?			<input type="checkbox"/>	<input checked="" type="checkbox"/>	
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 <input type="checkbox"/> .					
HEIGHT (cm): <u>163</u>	WEIGHT (kg): <u>50</u>	BLOOD PRESSURE: Systolic: <u>105</u> (mm Hg) Diastolic: <u>60</u> (mm Hg)	PULSE RATE <u>71</u> /min RHYTHM: _____	RESPIRATION: <u>105</u> /min	BMI: <u>23.6</u>
VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION	EAR	Hearing by Audiometry
Uncorrected	OD 20/   OS 20/	ODJ   OSJ	Adequate <input type="checkbox"/>	Right	<input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
Corrected	OD 20/   OS 20/	ODJ   OSJ	Defective <input type="checkbox"/>	Left	<input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate
					CLARITY OF SPEECH
					Adequate <input 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 checked="" type="checkbox"/>		Genito-urinary System	<input checked="" type="checkbox"/>	
Head, neck, scalp	<input checked="" type="checkbox"/>		Chest-Breast-Axilla	<input checked="" type="checkbox"/>		Inguinals, Genitals	<input checked="" type="checkbox"/>	
Eyes, external	<input checked="" type="checkbox"/>		Lungs	<input checked="" type="checkbox"/>		Extremities	<input checked="" type="checkbox"/>	
Pupils, Ophthalmoscopic	<input checked="" type="checkbox"/>		Heart	<input checked="" type="checkbox"/>		Reflexes	<input checked="" type="checkbox"/>	
Ears	<input checked="" type="checkbox"/>		Abdomen	<input checked="" type="checkbox"/>		Dental (Teeth/Gums)	<input checked="" type="checkbox"/>	
Nose, Sinuses	<input checked="" type="checkbox"/>		Back	<input checked="" type="checkbox"/>				
Mouth, Throat	<input checked="" type="checkbox"/>		Anus-rectum	<input checked="" type="checkbox"/>				

  

III. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (✓) in the appropriate box <input type="checkbox"/> .		
A CHEST X-RAY <input checked="" type="checkbox"/> Normal <input type="checkbox"/> With Findings	D. URINALYSIS <input checked="" type="checkbox"/> Normal <input type="checkbox"/> With Findings	G. HIV/AIDS Test (when required) <input type="checkbox"/> Reactive <input checked="" 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 RPR and/or TPHA <input type="checkbox"/> Reactive <input checked="" type="checkbox"/> Non-Reactive
C CBC: <input checked="" 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): <u>A</u>
PSYCHOLOGICAL TEST (when required): <input type="checkbox"/> Normal <input type="checkbox"/> 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 <input type="checkbox"/> .	
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 <input type="checkbox"/> .	
On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the examinee medically.	
<b>FIT FOR LOOK-OUT DUTY</b> <input checked="" type="checkbox"/> <b>NOT FIT FOR LOOK-OUT DUTY</b> <input type="checkbox"/>	
<b>DECK SERVICE</b> FIT <input checked="" type="checkbox"/> UNFIT <input type="checkbox"/>	<b>ENGINE SERVICE</b> FIT <input checked="" type="checkbox"/> UNFIT <input type="checkbox"/>
<b>CATERING SERVICE</b> FIT <input checked="" type="checkbox"/> UNFIT <input type="checkbox"/>	<b>OTHER SERVICES</b> FIT <input checked="" type="checkbox"/> UNFIT <input type="checkbox"/>
WITH RESTRICTIONS: <input type="checkbox"/> WITHOUT RESTRICTIONS: <input checked="" type="checkbox"/> VISUAL AIDS REQUIRED: YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Describe restrictions** (refer to standard restrictions at the bottom of this page).	

  

DATE OF MEDICAL EXAMINATION: <u>03/10/2022</u>	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: <u>03/10/2024</u>	MEDICAL EXAMINATION REPORT NO: <u>10755</u>
DAY MONTH YEAR	DAY MONTH YEAR	

  

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: <u>DR. OLIVIA RODRIGUEZ</u>	
LICENSE NUMBER: <u>178899</u>	
ADDRESS: <u>187 DURIAN ST. QUARTER CDDU</u>	

  

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 \_\_\_\_\_.

<u>MARIE C. FRANA</u> NAME AND SIGNATURE OF SEAFARER	<u>03/10/2023</u> DATE
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THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

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

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• No solo watchkeeping</li> <li>• Not fit for emergency duties</li> <li>• Not fit for lookout duties</li> <li>• Only fit for lookout during daylight hours</li> <li>• Not fit for work with colour coded tables etc</li> <li>• Not to be away from (home) port overnight</li> <li>• Not to be away from (home) port for periods over 24 hours/7days</li> <li>• Not to lift items weighing over 5/10/20/40kg</li> <li>• Protective gloves to be worn for work with (specify)</li> <li>• Eye protection to be worn for all work</li> </ul> | <ul style="list-style-type: none"> <li>• Not to work with (specify)</li> <li>• Not fit for food handling</li> <li>• Within (specify) miles from a safe haven</li> <li>• Near-coastal only</li> <li>• Coastal waters only, up to (specify) miles from shore</li> <li>• Non-tropical waters only</li> <li>• Not fit for service on stand-by vessels</li> <li>• Fit for service only on vessels with ship's doctor</li> <li>• Toilet/washing facilities in private cabin required</li> <li>• Special needs in emergencies (specify)</li> </ul> |
|---|---|