This Seafarer Medical Certificate complies with STCW 1/9 or ILO-73 and Bahamian and Maltese Medical Standards or as approved by Countries with a Reciprocal Recognition Agreement, "Guidance for conducting Medical Fitness Examination for Seafarers"

RCL EMPLOYMENT MEDICAL EXAMINATION FORM A

(New and Returning Crew)

Family Name:	Given Name:		Gender: ☐Male ☐Female	Birth Date (day/month/year):	Crew Position:
Seaman's Book No.:	Crew I.D. No.:	ID Confirmed? ☐ Yes ☐ No	Passport No.:		Nationality:
City of Residence:	Country of Residence:	Vessel:	Type of Ship: Passenger		Trade Area: Worldwide

DO YOU HAVE,DID YOU EVER HAVE OR HAVE YOU BEEN TOLD YOU HAVE: (to be completed by crew member)

IF YOU ANSWER "Yes" TO ANY OF THE QUESTIONS IN THIS SECTION,PLEASE PROVIDE AN EXPLANATION ON THE NEXT PAGE.
If you do not understand any terms you must ask you medical provider to explain.

	CONDITION	Yes	No
1.	Do you feel healthy and fit to perform the duties of your designated position/occupation? If "No" specify below:	☐	☐
	Explanation:		
2.	Have you ever been declared unfit for sea duty?	☐	☐
3.	Has your medical certificate ever been restricted or revoked?	☐	☐
4.	Have you signed off as sick or repatriated from a ship?	☐	☐
5.	Are you aware that you have any medical problems, diseases, or illnesses?	☐	☐
6.	Do you drink alcohol? How much per day: ____week:___	☐	☐
7.	Do you smoke? How many Years? How much per day?	☐	☐
8.	Have you ever been **Hospitalized**? For What? When?	☐	☐
9.	Have you had **ANY** type of surgery? For What? When?	☐	☐
10.	Have you ever received a blood transfusion? Why?	☐	☐
11.	Are you taking **ANY** medications?	☐	☐
12.	Alternative Medicine or Treatment? What?	☐	☐
	PSYCHIATRIC		
13.	Attempted Suicide?	☐	☐
14.	Ever had thoughts of Harming Self or Others?	☐	☐
15.	Psychiatric Problems / Bipolar / Other Disorders?	☐	☐
16.	Nervous Breakdown / Depression /Anxiety?	☐	☐
17.	Attention deficit/hyperactivity disorder (ADHD)?	☐	☐
18.	Difficulty Concentrating on Things?	☐	☐
19.	Trouble Falling Asleep, Staying Asleep or Sleeping too much?	☐	☐
	ORTHOPEDIC		
20.	Neck Pain/ Scoliosis / Cervical Injury / Radiating Pain?	☐	☐
21.	Back pain / Injury / Sciatica/ Radiating Pain?	☐	☐
22.	Hand / Wrist Pain or Numbness?	☐	☐
23.	Elbow Pain / Injury / Surgery?	☐	☐
24.	Shoulder Pain / Injury / Surgery?	☐	☐
25.	Knee Pain / Injury / Surgery / Osteoarthritis?	☐	☐
26.	Feet Pain / Numbness / Tingling / Injury / Surgery / Heel Pain?	☐	☐
27.	Sprains / Dislocations / Fractures?	☐	☐
	INFECTIOUS DISEASES		
28.	Rheumatic Fever (autoimmune)?	☐	☐
29.	Infectious / Contagious Diseases?	☐	☐
30.	Syphilis/HIV/Gonorrhea/Other Sexually Transmitted Disease?	☐	☐
31.	Hepatitis: A ☐ B ☐ C ☐?	☐	☐
32.	Tuberculosis (TB)? Date: ____/____/_____	☐	☐
33.	Yellow Fever / Scarlet Fever / Malaria / Tropical Diseases?	☐	☐
34.	Viral/Mononucleosis/Chicken Pox/ Measles/Mumps?	☐	☐

	CONDITION	Yes	No
	CARDIAC		
35.	Chest Pain? Palpitations?	☐	☐
36.	Heart Attack / Irregular Heart Beat / Rate?	☐	☐
37.	Heart Disease?	☐	☐
38.	Heart Surgery / Pacemaker / ICD Implantable (cardiac defibrillator) ?	☐	☐
39.	High Blood Pressure? Date of Diagnosis: ____/____/_____	☐	☐
	ENDOCRINOLOGY		
40.	Diabetes? ☐Type Unknown☐Type I☐ Type II	☐	☐
41.	Thyroid (weight loss, sweats, tremors) or Other Endocrine Disorders?	☐	☐
	GASTROENTEROLOGY		
42.	Gastritis / Reflux / Gastric or Duodenal Ulcer?	☐	☐
43.	Frequent Diarrhea or Constipation / Straining / Pain?	☐	☐
44.	Bleeding from Stomach or Bowels?	☐	☐
45.	Hemorrhoids / Rectal Bleeding?	☐	☐
46.	Jaundice (Yellow Eyes/Skin) / Gallbladder / Liver Problems	☐	☐
47.	Hernias of Any Kind / Hernia Surgery?	☐	☐
48	Abdominal Pain?	☐	☐
	PULMONARY		
49.	Asthma or Wheezing?	☐	☐
50.	Bronchitis?	☐	☐
51.	Pneumonia?	☐	☐
52.	Coughing Up Blood?	☐	☐
53.	Pulmonary Embolism?	☐	☐
54.	Shortness of Breath?	☐	☐
55.	Sleep Apnea?	☐	☐
	NEUROLOGY		
56.	Headaches / Dizziness / Loss of Consciousness?	☐	☐
57.	Head Injury or Concussion?	☐	☐
58.	Fainting?	☐	☐
59.	Seizures / Epilepsy / Receiving Medications for Either?	☐	☐
60.	Loss of Memory?	☐	☐
61.	Stroke / Mini-Stroke (TIA)?	☐	☐
62.	Muscular Weakness?	☐	☐
	BLOOD DISORDERS		
63.	Anemia / Sickle Cell Anemia?	☐	☐
64.	Hemophilia?	☐	☐
65.	Leukemia?	☐	☐
66.	Other Blood Disorders?	☐	☐
	UROLOGY		
67.	Kidney Problems / Dialysis?	☐	☐
68.	Bladder Infection / Blood in Urine / Kidney Stones?	☐	☐
69.	Prostate Disease (Males)?	☐	☐

	CONDITION	Yes	No
	OPHTHALMOLOGY		
70.	Glaucoma?	☐	☐
71.	Conjunctivitis?	☐	☐
72.	Do you wear glasses / contact lenses?	☐	☐
73.	Eye Injury / Eye or Vision Problems?	☐	☐
74.	Cataracts?	☐	☐
75.	Macular Degeneration History?	☐	☐
76.	Eye Surgery?	☐	☐
77.	Color Blindness?	☐	☐
	EAR, NOSE, & THROAT		
78.	Frequent Ear Infections?	☐	☐
79.	Hearing Loss / Hearing Aids?	☐	☐
80.	Frequent Colds / Sinus Trouble?	☐	☐
81.	Nose Bleed (Adulthood)?	☐	☐
82.	Frequent Sore Throat / Throat Problems or Hoarseness?	☐	☐
83.	Balance Problem / Meniere's Disease / Vertigo / Spinning Sensation?	☐	☐
	DERMATOLOGY		
84.	Skin Problems / Rashes?	☐	☐
85.	Skin Cancer or Tumors?	☐	☐
86.	Dermatitis?	☐	☐
87.	Psoriasis / Eczema?	☐	☐
	RHEUMATOLOGY		
88.	Lupus?	☐	☐
89.	Sarcoid Disease?	☐	☐
90.	Rheumatoid Arthritis?	☐	☐
91.	Joint Pains / Arthritis / Numbness in Extremities?	☐	☐

	CONDITION	Yes	No
	ALLERGIES		
92.	Allergies, Anaphylaxis to Environment, Chemicals, Food/Drugs	☐	☐
	VASCULAR		
93.	Varicose Veins / Varicose vein surgery?	☐	☐
94.	Poor Circulation?	☐	☐
95.	Gout?	☐	☐
	MISCELLANEOUS		
96.	Serious Accidents / Illnesses?	☐	☐
97.	Swollen Glands?	☐	☐
98.	Restricted Mobility?	☐	☐
99.	Implants?	☐	☐
100.	Cancer of any kind (malignant or benign or in remission)?	☐	☐
	GYNECOLOGY		
101.	Are you or do you think you may be pregnant?	☐	☐
102.	What was the date of your last menstrual period? ____/____/_____	☐	☐
103.	Abnormal Vaginal Bleeding?	☐	☐
104.	Gynecological / Female Problems?	☐	☐
105.	Fibroids / Ovarian Cyst?	☐	☐
106.	Frequent Bladder Infections?	☐	☐
107.	Ectopic Pregnancy?	☐	☐
108.	Breast Mass / Lumps /Tenderness? Date of Last Mammogram/Breast Ultrasound: ____/____/_____	☐	☐

CREW MEMBER SECTION **(tobe completedbycrew member)**

ALL "YES" RESPONSES ABOVE REQUIRE COMMENTS (IN ENGLISH)FROM THE CREW MEMBER AND MUST BE REVIEWED BY PHYSICIAN

Question #:	Comments:

Crew Member Section Reviewed and initialed by Physician: _____

PHYSICIAN SECTION: TO BE COMPLETED BY PHYSICIAN

ALL "YES" RESPONSES ABOVE REQUIRE COMMENTS (IN ENGLISH) FROM THE EXAMINING PHYSICIAN

Question #:	Comments:

CERTIFICATION

By signing below I hereby certify that the information contained in this form is true, correct, and complete to the best of my knowledge and belief. **I understand that any false information, misrepresentation, or omission of facts in this form are grounds for loss of benefits (including without limitation, medical benefits, sick pay, maintenance, death benefits, and disability benefits), disqualification from further consideration, and/or immediate termination of employment without recourse.**

SIGNATURE OF EXAMINEE	DATE	WITNESS NAME *(please print)*	WITNESS SIGNATURE	DATE

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I understand the purpose of this examination is for Royal Caribbean Cruises Ltd. and/or its affiliates ("RCL")

- To obtain information that may be used to determine fitness for duty and/or
- To comply with legal or other reporting obligations, and/or
- To investigate or evaluate any alleged or reported injury, loss, damage, crime and its or their causes or circumstances, and/or
- To assert or defend against legal claims.

To achieve the above purposes, I hereby request and authorize RCL to release all my medical records and information from any source, including without limitation, hospitals, clinics, labs, physicians, psychologists, employers, insurance companies, government authorities, and any other health professionals, health institutions, or public authorities (collectively, "Medical Records')to any RCL medical personnel, any third party performing medical record review, quality control entities, and any other person or entity necessary for RCL to determine or verify whether I am fit for duty.

In the event I make a claim for medical benefits, sick pay, death, or disability benefits, or any other benefits, I further authorize RCL to release all my Medical Records to RCL personnel to make a claim determination or resolve a claim dispute or appeal. I authorize the release of all my Medical Records to the physician(s) performing the medical examination subject of this form.

I authorize release of my Medical Records to any government authority such as the F.B.I. the U.S. Coast Guard, the Centers for Disease Control (CDC) or any other national, state or local authority either in the U.S> or abroad, or any other person or entity as may be required by law.

I hereby authorize the release of my Medical Records, including patient history, office notes, test results, radiology studies, films, referrals, consultants and billing records, even if said record(s) include information related to alcohol, drug abuse, mental health treatment, or confidential HIV related information, to me and/or my health insurer or any other entity from which I requested third party payment for the services provided at this medical facility.

Further, I acknowledge that my Medical Data might be transferred to countries outside the European Union (EU) and/or the European Economic Area (EEA). When we transfer your Medical Data outside the EU/EEA, the laws and rules that protect your Medical Data in such countries may be different (or less protective) from your own country. For example, the circumstances in which law enforcement can access your Medical Data may vary from country to country.

Your consent declaration is completely voluntary and you may as well revoke it at any time. The withholding or revocation of yourconsent will not have any negative, especially no disciplinary, consequences. However, RCL might not be able to assign you to certain tasks that require an approved level of fitness if you withhold or withdraw your consent. If you revoke your consent, this will not impact the legitimacy of the previous use of your data that was based on your initial declaration of consent. You may revoke your consent by email to privacy@rccl.com. If there is another legal basis for processing, RCL reserves the right to process the data on such other legal basis.

This authorization is executed in compliance with the Heath and Insurance Portability and Accountability Act (HIPAA) of 1996 and 45 C.F.R. Parts 160 and 164.

You can find all further information on the processing of your Personal Data including your rights to access, rectification and erasure of your data, and contact details for a revocation of your consent in the most recent version of our employee privacy notice available at: http://www.royalcaribbean.com/privacypolicy.

APPEAL PROCESS

The MLC, 2006 provides that seafarers that have been refused a medical certificate or have had a limitation imposed on their ability to work be given the opportunity to have a further examination by another independent medical practitioner or by an independent medical referee designated by the company. For more information how to file an appeal please contact PEMEREMEREVIEW@rccl.com.

My signature below signifies that, to the best of my knowledge and belief, all information, answers and responses provided to the company, or company affiliated physicians, labs or medical staff, are true and correct. I fully understand that I have an ongoing obligation to fully disclose any and all medical conditions which may affect my employment, whether listed above or not. I also agree to continuously update Royal Caribbean Cruises Ltd. or its affiliated brands with any and all medical information which arise subsequent to the date of this document. I fully understand that if I falsify or withhold relevant medical information or condition(s) and/or fail to provide Royal Caribbean Cruises Ltd. or affiliated brands with updated information as necessary subsequent to the date of this document, such action or inaction WILL SERVE AS GROUNDS FOR TERMINATION OF MY EMPLOYMENT WITHOUT EMPLOYMENT BENEFITS AND/OR MAINTENANCE OR CURE BENEFITS. I ALSO AUTHORIZE RELEASE OF ANY / ALL MEDICAL INFORMATION CONCERNING MY PAST, PRESENT OR FUTURE MEDICAL CONDITION(S), BY ANY MEDICAL PRACTITIONER OR PROVIDER, TO ROYAL CARIBBEAN CRUISES LTD. OR ITS AUTHORIZED REPRESENTATIVE. I AM ABLE TO READ, WRITE AND SPEAK ENGLISH AND FULLY UNDERSTAND ALL OF THE ABOVE INFORMATION.

SIGNATURE OF EXAMINEE	DATE	WITNESS NAME *(please print)*	WITNESS SIGNATURE	DATE

ACKNOWLEDGMENT BY PHYSICIAN

I acknowledge that I have reviewed the information contained in this form with the Applicant and noted Comments as required.

PHYSICIAN SIGNATURE	PHYSICIAN NAME *(please print)*	PHYSICIAN PHONE NUMBER	DATE