Optical Character Recognition using Tesseract

Written By: Migui Phillip G. Galan

Optical Character Recognition (OCR) is a technology that transforms printed or handwritten text into machine-encoded text. It plays a vital role in digitizing documents, automating data entry, and enabling text analysis for a wide range of applications. One of the most powerful and widely-used OCR engines available today is Tesseract.

Now, to challenge ourselves. We will try recognize characters from images.

Image acquisition

To start with, we will use the DOH forms (clear images can be seen below) provided in this challenge. These will be printed out to be filled with dummy data. Next, a scanner reads these documents and converts them to PNG images which we will use for the next step.

Text recognition tool

After multiple flavor taste from the suggested tools, I found Tesseract as my go-to tool for this activity mainly because it's an open-source code and its popularity in qualitative OCR-library.

How does it work?

Tesseract is finding templates in pixels, letters, words and sentences. It uses two-step approach that calls adaptive recognition. It requires one data stage for character recognition, then the second stage to fulfil any letters, it wasn't insured in, by letters that can match the word or sentence context.

Installation

```
sudo apt install tesseract-ocr
```

Running Tesseract

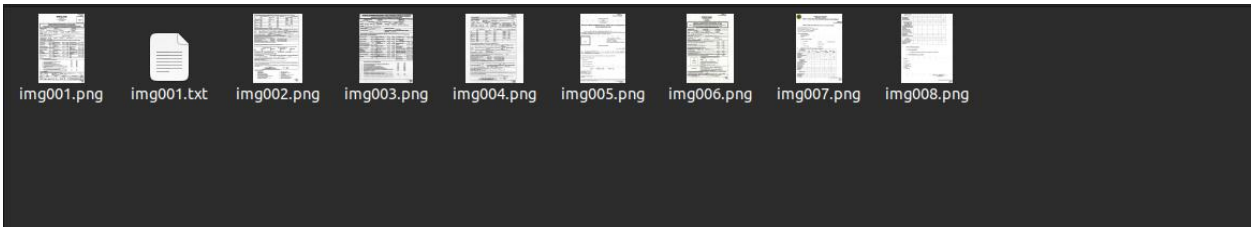
Tesseract is a command-line program, so first open a terminal or command prompt. The command is used like this:

```
tesseract imagename outputbase [-l lang] [-psm pagesegmode] [configfile...]
```

So basic usage to do OCR on an image called 'img001.png' and save the result to 'img001.txt' would be:

```
tesseract img001.png img001
```

Finally, to view the generated result. We will locate the .**txt** file within the working directory which should be 'img001.txt'.

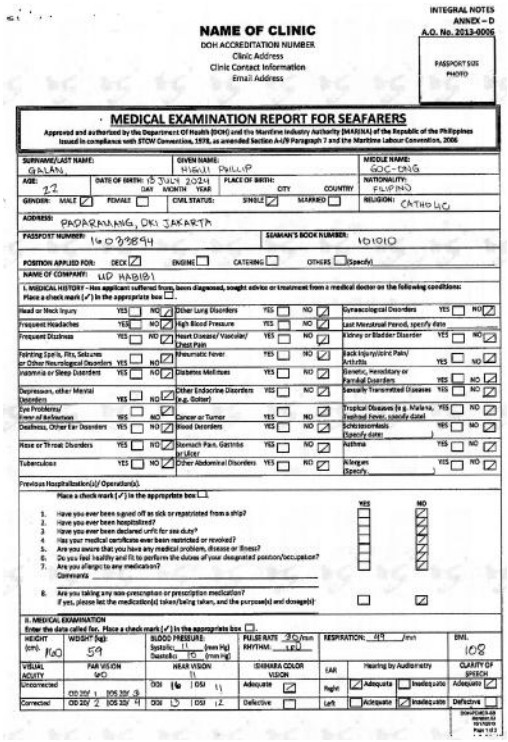


We will repeat this process until we have completely converted all images into encoded-text.

What are the results?

As the result was satisfactory for our use case, we will now match the accurateness of the encoded characters with the images. We won’t be using any tools for this to test the accurateness but we will solely rely on observation.

img001.png



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

PASSPORT SIZE PHOTO

NAME OF CLINIC
DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

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: GALAN, | GIVEN NAME: MIGUL PRILLIP | MIDDLE NAME: GOC-DNG
AGE: 22 | DATE OF BIRTH: DAY 15 MONTH JULY YEAR 2024 | PLACE OF BIRTH: CITY / COUNTRY | NATIONALITY: FILIPINO
GENDER: MALE ☑ FEMALE ☐ | CIVIL STATUS: SINGLE ☑ MARRIED ☐ | RELIGION: CATHOLIC
ADDRESS: PADARUANG, OKI JAKARTA
PASSPORT NUMBER: 1607338594 | SEAMAN'S BOOK NUMBER: 101010
POSITION APPLIED FOR: DECK ☑ ENGINE ☐ CATERING ☐ OTHERS ☐ (Specify)
NAME OF COMPANY: LLP HARBOR

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): 160	WEIGHT (kg): 59	BLOOD PRESSURE: Systolic: 11 (mm Hg) Diastolic: 70 (mm Hg)	PULSE RATE: 70/min RHYTHM: REG	RESPIRATION: 89 /min	BMI: 108

VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION	EAR	Hearing by Audiometry	CLARITY OF SPEECH
Uncorrected	OD 20/ 1 OS 20/ 3	OD |6 | OS | 11	Adequate ☑	Right	☑ Adequate ☐ Inadequate	Adequate ☑
Corrected	OD 20/ 2 OS 20/ 4	OD |5 | OS | 12	Defective ☐	Left	☑ Adequate ☐ Inadequate	Defective ☐

img001.txt

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ha oo, INTEGRAL NOTES


ANNEX – D
NAME OF CLINIC A.O. No. 2013-0006
DOH ACCREDITATION NUMBER
Clinic Address

PASSPORT SIZE

Clinic Contact Information
Email Address


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- 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 Para d the Maritime Labour Convention, 2006


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AME/LAST NAME:


SURN. GIVEN NAME: MIDDLE NAME:


GALAN, MIGQUL PRILLWP GOC-DNG
AGE: DATE OF BIRTH: (S SULN 20244 | PLACE OF BIRTH: NATIONALITY:
42 DAY MONTH YEAR ciTy COUNTRY | FILIP RD
GENDER: MALE[7] FEMALE [_] CIVIL STATUS: SINGLEL7]  MARRIED[ | REUGIONS CATS LC,
ADDRESS: CADAQAYKANG, OKI JAKARTA
: "S BOOK 7
PASSPORT NUMBER |. agay SEAMAN NUMBER SiG
posmon AppugpFor: – veck[Z] encineL_) __carerinc [_] oTHers [_](specity)



NAME CF COMPANY: = 440 BAKBIO\


1, MEDICAL HISTORY - Has applicant suffered fran, been diagnosed, sought advice or treatment from a medical doctor on the following conditions:
Place a check mark () In the appropriate box Lt.


Head or Neck Injury yes[" | NOT] Other Lung Disorders YES Cc] NO {A Gynaecological Disorders YES 7 nol]
Frequent Headaches YESL_| NO[/] High Blood Pressure YES [~] NO [Z] _ [ast Menstrual Period, specify date
Frequent Dizziness YES NO 7] Heart Disease/ Vascular? YES NO -= Kidney or@ladder Disorder YES NO
Cy l [Z} Grest Pain C {4 Oe
Fainting Spells, Fits, Selzures Rheumatic Fever YES | NO ack Injury/Joint Pain/
or Other Neurological Disorders YES CI nolZ] Ll 4) rthritls YES CI NO WA
Insomnia or Sleep Disorders YES CI NOL] Diabetes Melltues YES CJ NO tJ Genetlc, Hereditary or
Famlhal Disorders YES CS NO
Depression, other Mental Other Endocrine Disorders YES NO Sexually Transmitted Diseases YES NO
Disorders YES Ee NO [7] (e.g. Golter} L2 4) Cl {2)
Eye Problems/ Tropical Diseases (eg. Malana, YES NO
Frror of Refraction YES C] wok Cancer or Tumor YES ce N0 Tyohoid Fever, soacify date) Lal (4)
Deafness, OtherEar Disorders YES Cl NO[7] food Disorders YES | NO [A Behistosomiasis YES CL] NO
Specify date: )
Nose or Throat Disorders a NO[_/] Btomach Pain, Gastritis YES cn NO a) Asthna YES oO ND Al
or Ulcer
Tuberculosis YES [_] NO[Z]Pther Abdominal Disorders YES cl NO [7] Allergles YES rd NO mn
(Specify. )


Previous Hospitalization(s)/ Operation({s).
Place a check mark { / } In the appropriate box 1.


YES NO
1. Have you ever been signed off as sick or repatriated from a ship? Va
2. Have you ever been hospitalized? Wa
3 _ Have you ever been declared unfit for sea duty? Z]
4 Has your medical certificate ever been restricted or revoked? 4
5. Are you aware that you have any medical problem, disease or lliness? WA
6 a you feel healthy and fit to perform the dutles of your designated positlon/occupatlon? 7
7. Are you allergic to any medlcation? 7, |
Comments
8. Ara you takIng any non-prescription or prescrlptlon medlcation?
Lf yes, please lst the medlcation(s) taken/belng taken, and the purpose(s) and dosage(s): CJ a
Hl, MEDICAL EXAMINATION
Enter the data called for. Place a check mark (w') in the appropriate box [_1.
HEIGHT WEIGHT (kg): BLOOD eon PULSERATE 2 O/min | RESPIRATION: 44 {min BMI,
{en). Systolic:_1\ (nn He) | RHYTHM:
IO 54 Quastalic: [9 (nnHg) ; | 68
VISUAL FAR VISION NEAR VISION ISHIHARA COLOR EAR Hearing by Audlametry CLARITY OF
ACUITY 60 "\ VISION SPEECH
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Te l t\ 2 Rught |Ldd L3 Ic]
Corrected | GD20/ J 3O520/ Gf op 1} [oss |Z | Defectve [-] Left |L_JAdequate {[?]lnadequate | Defective [|
" =
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List of mistaken text:

Error	Correct	Error	Correct
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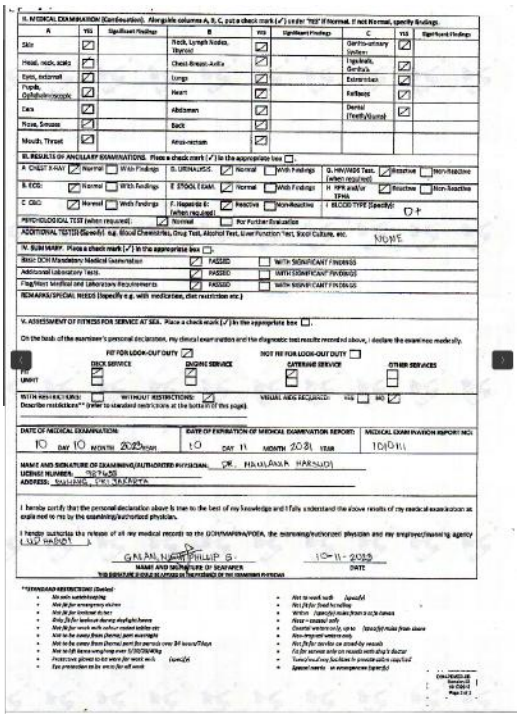
MIG@ULPRILLWP	MIGUI PHILLIP	(5 SULN 20244	13 JULY 2024
42	22	FILIP RO	FILIPINO
CADAQAYKANG, OKI	PADARAMANG, DKI	440 BAKBIO\	UD HABIBI
|. agay	16033894	Pther	Other
		lst	list

img002.png



img002.txt

```
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 A YES Significant Findings Cc YES Significant Findings
Neck, Lymph Nodes, Genito-urinary

= KI Thyroid System [4
Head, neck, scalp "1 Chest-Breast-Axilla oe [7]
Eyes, external 7} Lungs 7] Extremities
Pupils,

Ophthalmoscoptc ZI Heart 7 Reflexes [7]

Dental!

Ears Z] Abdonen (Teeth/Guns)
Nose, Sinuses I Back Y]

Mouth, Throat | Anus-rectum 1

lil. RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (#') in the appropriate box [_].

A CHEST X-RAY [t Normal ["] With Findings | D. URINALYSIS, 7 Normal [/ ]With Findings | G. HIV/AIDS Test. [7]
Reactive [_]Non-Reactive
(when required) S :

B. ECG: [7] Normal [_] With Findings | E STDDLEXAM. [7] Normal [7 JWith Findings | 4 RPR and/or [7] Reactive
[__]Non-Reactive
ese Ses ena. TPHA

c cac: Normal With Findings | F. Hepatitis 6: Reactive I JNon-Reactive | BLOOD TYPE (Specify):
vA) Cl (when required) vA UF

PSYCHOLOGICAL TEST (when required): Normal L_] For Further Evaluation

ADDITIONAL TEST(S) (Specify), e.g. Blood Chemistries, Drug Test, Alcohal Test, Liver Function Test, Stool Culture,
ate, N ON .

IV. SUMMARY. Place a check mark (v') in the appropriate box [-).

Basic DOH Mandatory Medical Examination 1] PASSED |_| WITH SIGNIFICANT FINDINGS

Additional Laboratory Tests. ie PASSED ] WITH SIGNIFICANT FINDINGS

Flag/Host Medical and Laboratory Requirements [7] PASSED [__] WITH SIGNIFICANT FINDINGS

REMARKS/SPECIAL NEEDS (Sspecify e.g. with medication, diet restriction ete.)

V. ASSESSMENT OF FITNESS FOR SERVICE AT SEA. Place a check mark (v} in the appropriate box LJ.

On the basis of the examinee's personal declaration, my clinical examination and the diagnostic test results
recorded above, | declare the examinee medically,

FIT FOR LOOK-OUT DUTY [7] NOT FIT FOR LOOK-OUT DUTY [- |
DECK SERVICE ENGINE SERVICE CATERING SERVICE OTHER SERVICES
FIT < |
UNFIT =
WITH RESTRICTIONS: [| WITHOUT RESTRICTIONS: Fl VISUAL AIDS REQUIRED: = YES | f NO [7]

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:
IO pay 10 month 202% ean 10 oay \\_ month ZOZ\ year LOLA

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: OR. NAULANIA HARSUD)
LICENSENUMBER: ARFLHS
ADDRESS: DUMANG, PKI SAKARTA

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

I hereby authorize the retease of all my medical records te the DOH/MARINA/POEA, the examining/authorized physician
and my employer/manning agency
BO\

.

GALAN, NIGETTPHILRIP G- {O- \\- 2024
NAME AND SIG IRE OF SEAFARER DATE
THIS SIGNATURE SHOULD SE AFFIXED IN PRESENCE OF THE EXAMINING PHYSICIAN
**STANDARD RESTRICTIONS (Duties):
= Na sola watchkeeping . Notto work With — {specify}
. Not fit for emergency dutres . Not fit for food handling "
* Not fit for lookout duties e Within {specify} miles from a sofe haven
s Only fit far laokout during doylight hours . Necr-scogstal only
. Not fit for work with colaur coded tables etc . Coastal waters only, upta (specify) mules from shore
. Not to be away fron {home port overnight . Non-tropical waters only
* — Not to be away from {home} port for periods over 24 hours/7days . Not fit for service on stand-by vessels
* Not to tift ltens weighing over §/10/20/40kg * Fit for service only on vessels with ship's doctor
* Protective gloves ta be€ warn for work witli tspecify} . Toe (wasting jocilies in private cobin cequired
* Eye protection to ke worn for all work * — Specotneeds in emergencies (specify) Sr eee ealteseloal
COH-PEMER-SB
l Renston.33 f

' 10/17/2013
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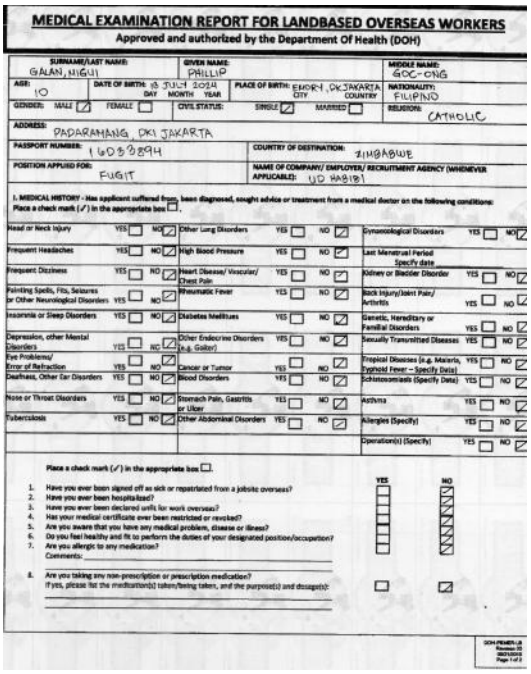
List of mistaken text:

Error	Correct	Error	Correct

NIGETTPHILMIP	MIGUI PHILLIP	Notto	Not to
SIG IRE	SIGNATURE	Specotneeds	Special needs
Na sola	No solo	b6€	be
ke	be	iift	lift
laokout	lookout	doylight	daylight
Necr-scogstal	Near coastal	sofe	safe
OR. NAULANIA	DR. MAULANIA	Ophthalmoscoptc	Ophtalmoscopic

img003.png



MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS

Approved and authorized by the Department Of Health (DOH)

SURNAME/LAST NAME: GALAN, MIGUI | GIVEN NAME: PHILLIP | MIDDLE NAME: GOC-ONG

AGE: 10 | DATE OF BIRTH: 12 JUL 2024 (DAY MONTH YEAR) | PLACE OF BIRTH: ELIORY, OK TAKARTA (CITY COUNTRY) | NATIONALITY: FILIPINO

GENDER: MALE ☑ FEMALE ☐ | CIVIL STATUS: SINGLE ☑ MARRIED ☐ | RELIGION: CATHOLIC

ADDRESS: PADARAMANG, OKI JAKARTA

PASSPORT NUMBER: 1603389H | COUNTRY OF DESTINATION: ZIMBABWE

POSITION APPLIED FOR: FUGIT | NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE): UD HABIBI

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 Mellitus	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 Data)	YES ☐	NO ☑
Deafness, Other Ear Disorders	YES ☐	NO ☑	Blood Disorders	YES ☐	NO ☑	Schistosomiasis (Specify Data)	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 ☑
						Operation(s) (Specify)	YES ☐	NO ☑

Place a check mark (✓) in the appropriate box ☐.

	YES	NO
1. Have you ever been signed off as sick or repatriated from a jobsite overseas?	☐	☑
2. Have you ever been hospitalized?	☐	☑
3. Have you ever been declared unfit for work overseas?	☐	☑
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):	☐	☑

img003.txt

```
MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS

Approved and authorized by the Department Of Health (DOH)

SURNAME/LAST NAME: GIVEN NAME: MIDDLE NAME: a
GANAN, MIGU| PHILLIP GOC- ONG
| AGE: DATE OF BIRTH: 12 JU 2024 | PLACE OFBIRTH: ELIORY OK TAKARTA| NATIONALITY:
(oO DAY MONTH YEAR clry COUNTRY ae
GENDER: MALE FIMALE CIVIL STATUS: SINGLE MARRIED
[4 Cj ld] ca e Cao.

MORES PADARAMANG OKI SAKARTA

na (GOR cay SO TL WORBWE
POSITION APPLIED FOR: NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEYER
Fugit APPLICABLE): 4) HAZIa\

1, MEDICAL HISTORY - Pree ee cannea ee ee ater tantinest ett» emall doctor ty the Indowing galiinlones
Place a check nark (/) in the appropriate box

Head or Neck Injury YES NOL_7] Pther Lung Disorders ves [3 no [7] "Gynaecological Disorders Ys] "7
Frequent Headaches yes|__| NO[_/] High Blood Pressure YES [] NO [-} hast Menstrual Period
Specify date
Frequent Dizziness YES NO Heart Disease/Vascular/ == YES NO Kidney or Bladder Disorder YES NO
St Cj Et = IZ
Fainting Spells, Fits, Seizures Fever YES NO ck Injury/Ioint Pain/
Prot NeureLogcal Dsorders ves] yop Cy ee we ae
Insomnia or Sleep Disorders YES NO[_-] Diabetes Mellitues YES NO enetic, Hereditary or :
Cj (4 CI a wile?
Other Endocrine Disorders ves] NOT A Bexually Transmitted Diseases YES L NO [7
6.8. Goite7)
Tropical Diseases (e.g. Malaria, YES NO
Cancer or Tunor CI NO [2] Fever -$ Cj ee

Nyphold Fever-Specify Date)
pean SE] NO [7] _ Pehistosomiasis (Specify Date) ves[_] NO [7

Nose or Throat Disorders YES NO Pain, Gastritis YES NO asthna YES NO >
L3 No1] fronad a pe a nae =,

Tuberculosis ves] NO Abdominal Disorders or NO Iargles (Specify) Yes 7] NO 7
; fan (Specify) ves [=] NO eC

Place a check nark (/) in the appropriate box L_].

YES
Have you ever been signed off as sick or repatriated from a jobsite overseas?
Have you ever been hospitalized?
Have you ever been declared unfit for work overseas?
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:

Ee

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8. Are you taking any non-prescription or prescription medication?
if yes, please list the medication(s) taken/being taken, and the purposets) and desage(s):

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Page 1 of 2

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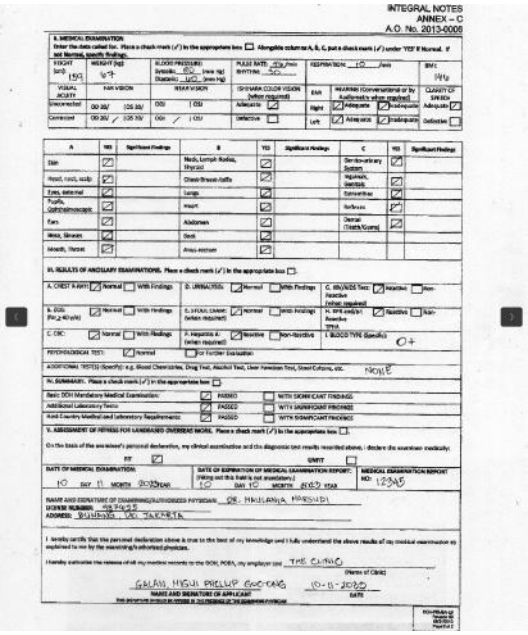
List of mistaken text:

Error	Correct	Error	Correct
MIGU|	MIGUI	ELIORY OK TAKARTA	EMORY, DK JAKARTA
4) HAZI®\	UD HABIBI	lergies	allergies
12 JU 2024	13 JULY 2024	Dsorders	Disorders
Pree ee canmea ee ee ater tnntinent ett» email doctor ty the lndowing gaiiiniones	Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions	Bexually	Sexually
		Spetis	Spell

img004.png



img004.txt

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INTEGRAL NOTES
ANNEX - C
A.O. No. 2013-0006

II. MEDICAL EXAMINATION :
Enter the data called for. Place a check mark (v') in the appropriate box [7]. Alongside columns A, G, ¢, puta check
mark (/ ) under 'YES' If Normal. If
not findings.
HEIGHT WEIGHT (kg): BLOOD PRESSURE: PULSE RATE: _4{(o /Min RESPIRATION: __ (o (Min BMI:
(em): + Systolic: (mn He) | RHYTHM: On 14
154 Diastolic: _ (9 _ (mn Hg) 0)
VISUAL FAR VISION NEAR VISION ISHIHARA COLOR VISION EAR HEARING (Conversational or by | CLARITY OF
ACUITY (When required) Audionetry when fred SPEECH
Uncorrected | Op 297  jos28/ | OD | Osi Adequate right |Z] Adequate ate} Adequate[7]
Corrected Ob20/ y |0528/ | obi , Jas Defective | | tefe  |LZZ] Adequate pn Defective Cy
A YES | Significant Findings B YES | Signiftcant Findings ¢€ YES | Significant Findings
Neck, Lymph Nodes, Genito-urinary | [7]
- 7] Thyroid 4) system
Head, neck, scalp chest-Sreast-Axiltz Ye pny Do
Eyes, external Lungs L Extremities dw
Pupils,
. a fevvee 1) Heart a Reflexes al
Dental
Ears Abdomen | (Teeth/Gums) | P|
Nose, Sinuses bg Back id
Mouth, Throat Lal Anes-rectum CF}

It, RESULTS OF ANCILLARY EXAMINATIONS. Place a check mark (¥) in the appropriate box [-].

A. CHEST X-RAY:[ 7] Normal [ _] With Findings | D. URINALYSIS: [JNormal [lth Findings = silage Test: Reactive |
_[Non-
: — as (when coqured)

- <n = we) Normal |__| With Findings eee ae | WA Normal | [With Findings tea = [7] Reactive [_[Non-

C. CBC: [21 Normal [7] With Findings : — . [-]Reactive [— Non-Reactive | |. BLOOD TVPE (Specify): Ot

PSYCHOLOGICAL TEST: 1Z] Normal [__For Further Evaluation «

ADDITIONAL TEST(S) (Specify): e.g. Blood Chemistries, Drug Test, Alcohol Test, Liver Function Test, Stool Culture,
atc. Noy E

lV. SUMMARY. Place a check mark (¥) in the appropriate box [7].

Basic DOH Mandatory Medical Examination: LZ] Passed |_| WITH SIGNIFICANT FINDINGS
Additonal Laboratory Tests: PASSED WITH SIGNIFICANT FINDINGS
Host Country Medical and Laboratory Requirements: PASSED WITH SIGNIFICANT FINDINGS

V. ASSESSMENT OF FITNESS FOR LANDBASED OVERSEAS WORK. 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, | declare the examinee medlcally:

FIT YW] UNFIT C]
DATE OF MEDICAL EXAMINATION: . GATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: | MEDICAL EXAMINATION REPORT
(Filling out this field is not mandatory.) NO: 12ZOK5
{0 _pay_\\_ month ZOD reer 10 DAY {o MONTH 902% year
NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN:__DR. NAULAN (A HARSUO\
LICENSE NUMBER: 6 F(o
ADpRESs: QUNN VE SAKRETA

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

\ hereby authorize the release of all my medical records to the DOH, POEA, my employer and THE CLG

(Name of Cfinic)
GALAN, HIGUI PEELLIP Goc Ong {0- \\. 28%
NAME AND SIGNATURE OF APPLICANT DATE
SHOULD BE EXAMINING PHYSICIAN


CBist201
Paoe2ol2
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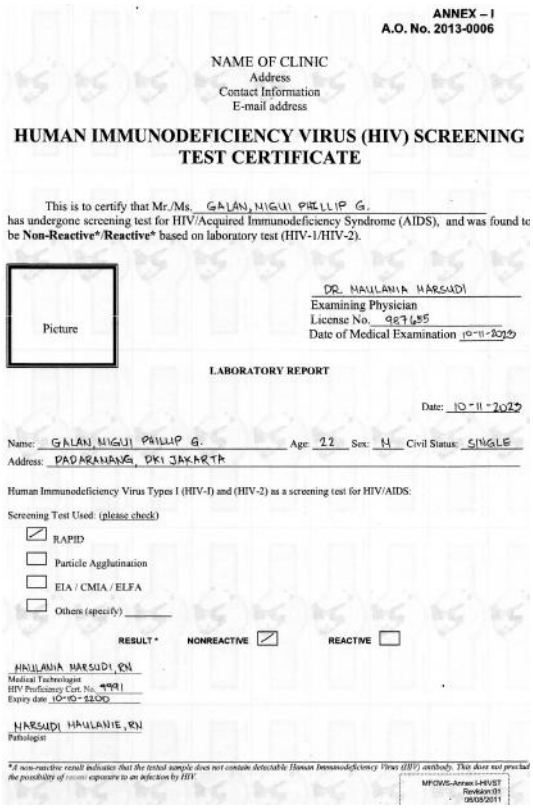
List of mistaken text:

Error	Correct	Error	Correct
Plece	Place	Normai	Normal
HIGUI PEELLIP	MIGUI PHILLIP	}	I

CLG	CLINIC	{O- \\- 20%	10-11-2033
ADpREss	ADDRESS	6 F(o	987655
__DR. NAULAN (A HARSUD\	DR. MAULANIA MARSUDI	DUNN VE SAKRETA	BUNANG, DKI JAKARTA

img005.png



ANNEX – I
A.O. No. 2013-0006

NAME OF CLINIC
Address
Contact Information
E-mail address

HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING TEST CERTIFICATE

This is to certify that Mr./Ms. GALAN, NIGUI PHELLIP G.
has undergone screening test for HIV/Acquired Immunodeficiency Syndrome (AIDS), and was found to be **Non-Reactive*/Reactive*** based on laboratory test (HIV-1/HIV-2).

Picture

DR. MAULANIA HARSUDI
Examining Physician
License No. 987655
Date of Medical Examination 10-11-2029

LABORATORY REPORT

Date: 10-11-2029

Name: GALAN, NIGUI PHILLIP G. Age: 22 Sex: M Civil Status: SINGLE
Address: PAO ARAMANG, DKI JAKARTA

Human Immunodeficiency Virus Types I (HIV-I) and (HIV-2) as a screening test for HIV/AIDS:

Screening Test Used: (please check)

☑ RAPID
☐ Particle Agglutination
☐ EIA / CMIA / ELFA
☐ Others (specify) _____

RESULT * NONREACTIVE ☑ REACTIVE ☐

MAULANIA HARSUDI, RN
Medical Technologist
HIV Proficiency Cert. No. 4991
Expiry date 10-10-2200

NARSUDI MAULANIE, RN
Pathologist

*A non-reactive result indicates that the tested sample does not contain detectable Human Immunodeficiency Virus (HIV) antibody. This does not preclude the possibility of recent exposure to an infection by HIV

MFOWS-Annex I-HIVST
Revision:01
06/08/2011

img005.txt

```
ANNEX -]
A.O. No. 2013-0006

NAME OF CLINIC
Address
Contact Information

E-mail address

HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING
TEST CERTIFICATE

This is to certify that Mr./Ms._ GALAN, NIGUA PHELLIP G.
has undergone screening test for HIV/Acquired Immunodeficiency Syndrome (AIDS), and was found to
be Non-Reactive*/Reactive* based on laboratory test (HIV-1/HIV-2).

DR. MAULANA BARSUDI
Examining Physician
License No. 98% [.59
Date of Medical Examination 1o7\\-202%




Picture

[=

LABORATORY REPORT
Date: 30-11-2029
Name: GALAN, NIGU PILPG. Age: 22 Sex: N_ Civil Status: SINGLE


Address: PAO ARAMANG, PKI TAKARTHE

Human Immunodeficiency Virus Types I (HIV-I and (HIV-2) as a screening test for HIV/AIDS:
Screening Test Used: (please check)

RAPID

Go Particle Agglutination

LI EIA / CMIA / ELFA

Lal Others (specify)

RESULT * NONREACTIVE REACTIVE Pe]

NAULANIA HARSUDI @H

Medical Technologist
UTY Dan fficiency Cont Ny ANG |

gaa V ETOLICINCY Vere ino.

Expiry date_ 10710-2208


NARSUD, HAULANIE , RN

Pathologist




*A non-reactive result indicates that the tested sample does not contain detectable Human Immunodeficiency Virus
(HIV) antibody. This does not preclud
the neuththh frecadt cena wo an Hechon te DIV. prvennnnnnnnnnnnnnnnnny :
f a _ y . : MFOWS-Annex I-HIVST :
Revision:01 :
06/08/2011 :
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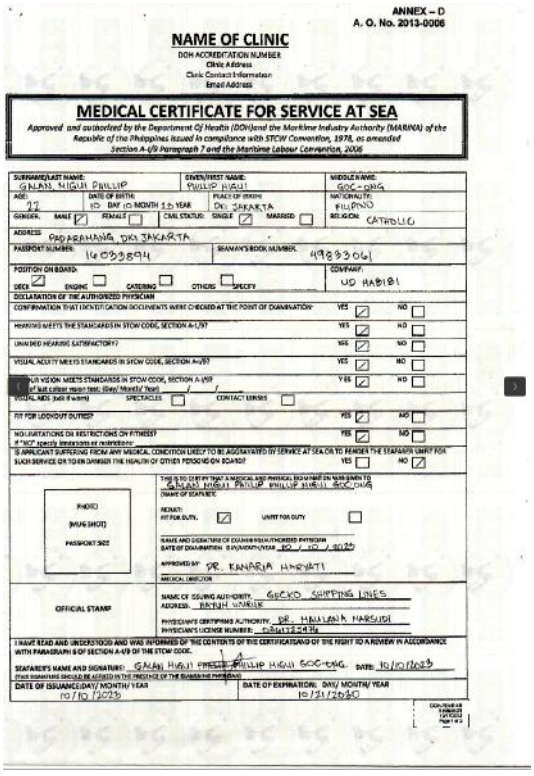
List of mistaken text:

Error	Correct	Error	Correct
NIGUA PHELLIP	MIGUI PHILLIP	N_	M

te	to	PAO ARAMANG, PKI TAKARTHE	PADARAMANG, DKI JAKARTA
NARSUD, HAULANIE	MARSUDI MAULANIE	10710	10-10
gaa V £TOLICINCY Vere ino.	HIV Proficiency Cert. No.	NAULANIA HARSUDI @N	MAULANIA MARSUDI, RN

img006.png



ANNEX – D
A. O. No. 2013-0006

NAME OF CLINIC
DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL CERTIFICATE FOR SERVICE AT SEA

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: GALAN, MIGUI PHILLIP | GIVEN/FIRST NAME: PHILLIP MIGUI | MIDDLE NAME: GOC-ONG
AGE: 27 | DATE OF BIRTH: 10 DAY 10 MONTH 15 YEAR | PLACE OF BIRTH: DKI JAKARTA | NATIONALITY: FILIPINO
GENDER: MALE ☑ FEMALE ☐ | CIVIL STATUS: SINGLE ☑ MARRIED ☐ | RELIGION: CATHOLIC
ADDRESS: PADARAMANG DKI JAKARTA
PASSPORT NUMBER: le033894 | SEAMAN'S BOOK NUMBER: 49833061
POSITION ON BOARD: DECK ☑ ENGINE ☐ CATERING ☐ OTHERS ☐ SPECIFY | COMPANY: UD HABIBI

DECLARATION OF THE AUTHORIZED PHYSICIAN

CONFIRMATION THAT IDENTIFICATION DOCUMENTS WERE CHECKED AT THE POINT OF EXAMINATION:	YES ☑ NO ☐
HEARING MEETS THE STANDARDS IN STCW CODE, SECTION A-I/9?	YES ☑ NO ☐
UNAIDED HEARING SATISFACTORY?	YES ☑ NO ☐
VISUAL ACUITY MEETS STANDARDS IN STCW CODE, SECTION A-I/9?	YES ☑ NO ☐
COLOUR VISION MEETS STANDARDS IN STCW CODE, SECTION A-I/9	YES ☑ NO ☐
Date of last colour vision test: (Day/ Month/ Year) / /	
VISUAL AIDS (Trek if worn) SPECTACLES ☐ CONTACT LENSES ☐	
FIT FOR LOOKOUT DUTIES?	YES ☑ NO ☐
NO LIMITATIONS OR RESTRICTIONS ON FITNESS?	YES ☑ NO ☐
If "NO" specify limitations or restrictions:	
IS APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY SERVICE AT SEA OR TO RENDER THE SEAFARER UNFIT FOR SUCH SERVICE OR TO EN DANGER THE HEALTH OF OTHER PERSONS ON BOARD?	YES ☐ NO ☑

PHOTO (MUG SHOT) PASSPORT SIZE

THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO GALAN MIGUI PHILLIP PHILLIP MIGUI GOC-ONG
NAME OF SEAFARER
RESULT: FIT FOR DUTY. ☑ UNFIT FOR DUTY ☐
NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN
DATE OF EXAMINATION: DAY/MONTH/YEAR 10 / 10 / 2023
APPROVED BY: DR. KAMARIA HARYATI
MEDICAL DIRECTOR

OFFICIAL STAMP
NAME OF ISSUING AUTHORITY: GECKO SHIPPING LINES
ADDRESS: BINTH WUNNIK
PHYSICIAN'S CERTIFYING AUTHORITY: DR. MAULANA MARSUDI
PHYSICIAN'S LICENSE NUMBER: 0341132438

I HAVE READ AND UNDERSTOOD AND WAS INFORMED OF THE CONTENTS OF THE CERTIFICATEAND OF THE RIGHT TO A REVIEW IN ACCORDANCE WITH PARAGRAPH 6 OF SECTION A-I/9 OF THE STCW CODE.

SEAFARER'S NAME AND SIGNATURE: GALAN MIGUI PHILLIP PHILLIP MIGUI GOC-ONG DATE: 10/10/2023
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

DATE OF ISSUANCE:DAY/ MONTH/ YEAR	DATE OF EXPIRATION: DAY/ MONTH/ YEAR
10/10/2023	10/21/2030

img006.txt

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ws : | : ANNEX - D

| A. e. No. 2013-0006
NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information

Email Address

MEDICAL CERTIFIC 'AT SEA

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 4-1/9 Paragraph Maritime Labour Convention, 2006 |

SURNAME/LAST NAME: GIVEN/FIRST NAME: MIDDLE NAME:
GALAN, MIGUI PHILLIP FUALLIP WIGU\ GOC- ONG
AGE: DATE OF BIRTH: PLACE OF BIRTH: NATIONALITY:
VLg (e DAY \e MONTH 9 % YEAR OKi SAKAR TA FIUPIND
GENDER. MALE FEMALE CIVILSTATUS: SINGLE MARRIED RELICION:
C] [7] f 3 CATHOLI0
ADDRESS
PAD ARAMANG DK JAKARTA £
PASSPORT NUMBER: SEAMAN'S BOOK NUMBER.
\eoogsauyu 44293 0b}
POSITION ON BOARD: COMPANY:
co lo | ro
veor! a encne ~_carcana CI otuers ~kpecley UD HABID\
DECLARATION OF THE AUTHORIZED PHYSICIAN
CONFIRMATION THAT IDENTIFICATION DOCUMENTS WERE CHECKED AT THE POINT OF EXAMINATION: YES 7] N0 tz
HEARING MEETS THE STANDARDS IN STCW CODE, SECTION A-1/9? YES a NO c
UNAIDED HEARING SATISFACTORY? YES NO Fa
VISUAL ACUITY MEETS STANDARDS IN STCW CODE, SECTION A-1/9? YES NO Ea
COLOUR VISION MEETS STANDARDS IN STCW CODE, SECTION A-1/9? : en ee ES Pal : NO Cl
Date of last colour vision test: (Day/ Month/ Year) / -
VISUAL AIDS (Trek if worn) SPECTACLES = CONTACT LENSES C
FIT FOR LOOKOUT OUTIES? YES 1 no Es1
NO LIMITATIONS OR RESTRICTIONS ON FITNESS? YES NO
If "NO" specify kmitations or restrictions: j CI]
1S APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY SERVICE AT SEA OR TO RENDER THE SEAFARER UNFIT FOR
SUCH SERVICE OR TO ENDANGER THE HEALTH OF OTHER PERSONS ON BOARD? YES 4 NO [A
THIS 1S TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO
GALAN MGM PRICLIE PRILLIE Dladl GOC- ONG
(NAME OF SEAFARER]
PHOTO
RESULT:
FIT FOR DUTY. 7] UNFIT FOR DUTY C]
(MUG SHOT)
NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN
PASSPORT Is DATE OF EXAMINATION DAY/MONTHAVEAR JO / (e) 7
APPROVED EY DR. KAMARA KrRYATI
MEDICAL DJRECTOR
NAME OF ISSUING AUTHORITY. __GECKO SHIPPING LINES
OFFICIAL STAMP ADDRESS. _NANUM WUNNIK
| puysicran's certieving authority, DE. MAULANK MARSUDI
PHYSICIAN'S LICENSE NUMBER: e2(o(TZ2 54 Ho

THAVE READ AND UNDERSTOOD AND WAS INFORMED OF THE CONTENTS OF THE CERTIFICATEAND OF THE RIGHT TO A REVIEW IN ACCORDANCE
WITH PARAGRAPH 6 OF SECTION A-I/9 OF THE STCW CODE.

SEAFARER'S NAME AND SIGNATURE: _GALAN H\GU\ encon Acie W\G@UL_GOC-ONG. pare, 10/10/2029

(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSFIAN)

DATE OF ISSUANCE:DAY/ MONTH/ YEAR DATE OF EXPIRATION: DAY/ MONTH/ YEAR
(0/(Q 1/1024 10/21/2038
1 DuMPERE-sB
2 Revtcion.07
2 901772013
1 Page 1 of 2
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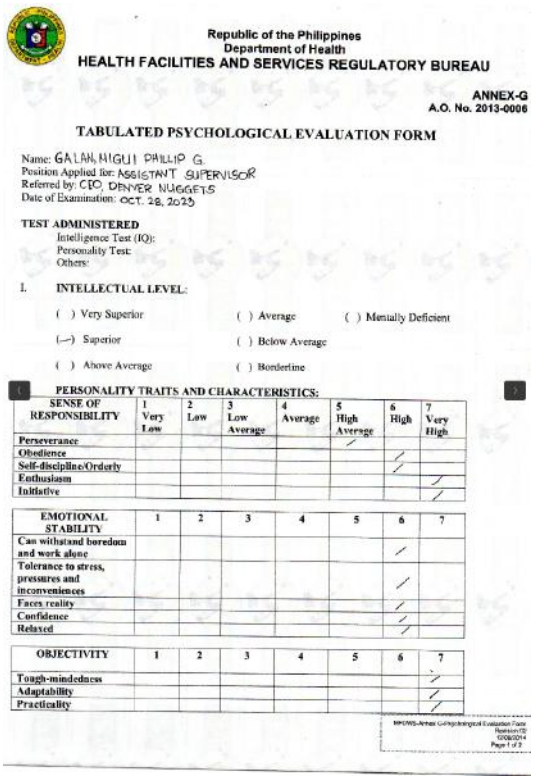
List of mistaken text:

Error	Correct	Error	Correct
Clinle	Clinic	FUALLIP WIGU\	PHILLIP MIGUI
CERTIFIC ‘	CERTIFICATE	FIUPINO	FILIPINO
GRLAN,	GALAN	CATHOLIO	CATHOLIC
DK	DKI	9 % {©	23
\eooggauyu 44293	49833061	vig	10
UD HABID\	UD HABIBI	\©	10
(0/(Q 1/1024	10/10/2023	_GALAN H\GU\ encom Acie W\G@UL_GOC-ONG.	GALAN, MIGUI PHILLIP PHILLIP MIGUI GOC-ONG

img007.png



Republic of the Philippines
Department of Health
HEALTH FACILITIES AND SERVICES REGULATORY BUREAU

ANNEX-G
A.O. No. 2013-0006

TABULATED PSYCHOLOGICAL EVALUATION FORM

Name: GALAN, MIGUI PHILLIP G.
Position Applied for: ASSISTANT SUPERVISOR
Referred by: CEO, DENVER NUGGETS
Date of Examination: OCT. 28, 2023

TEST ADMINISTERED
Intelligence Test (IQ):
Personality Test:
Others:

I. INTELLECTUAL LEVEL:

( ) Very Superior ( ) Average ( ) Mentally Deficient
(–) Superior ( ) Below Average
( ) Above Average ( ) Borderline

PERSONALITY TRAITS AND CHARACTERISTICS:

SENSE OF RESPONSIBILITY	1 Very Low	2 Low	3 Low Average	4 Average	5 High Average	6 High	7 Very High
Perseverance					/		
Obedience						/	
Self-discipline/Orderly						/	
Enthusiasm							/
Initiative							/

EMOTIONAL STABILITY	1	2	3	4	5	6	7
Can withstand boredom and work alone						/	
Tolerance to stress, pressures and inconveniences						/	
Faces reality						/	
Confidence						/	
Relaxed						/	

OBJECTIVITY	1	2	3	4	5	6	7
Tough-mindedness							/
Adaptability							/
Practicality							/

img007.txt

```
Republic of the Philippines
Department of Health
HEALTH FACILITIES AND SERVICES REGULATORY BUREAU

ANNEX-G
A.O. No. 2013-0006

TABULATED PSYCHOLOGICAL EVALUATION FORM

Name: GALAN, MIGU) PHILLIP G.
Position Applied for: AggigTANT GUPERVISOR

Referred by: CEO, DENVER NUGGETS
Date of Examination: oc 7. 28,2024

TEST ADMINISTERED
Intelligence Test (IQ):
Personality Test:
Others:

L, INTELLECTUAL LEVEL:

( ) Very Superior

(-) Superior

( ) Above Average

( ) Average

( ) Below Average

( ) Borderline

I. PERSONALITY TRAITS AND CHARACTERISTICS:

( ) Mentally Deficient

SENSE OF
RESPONSIBILITY

1
Very
Low

2
Low

3
Low
Average

4
Average

5
High

Average

6
High

Very
High

Saket

Perseverance

a"

Obedience

Self-discipline/Orderly

AWN

Enthusiasm

Initiative

NIN

EMOTIONAL
STABILITY

Can withstand boredom
and work alone

Tolerance to stress,
pressures and
inconveniences

Faces reality

Confidence

Relaxed

INI x Ny

OBJECTIVITY
```

List of mistaken text:

Error	Correct	Error	Correct
MIGU)	MIGUI		

oc 7. 28,2024 OCT. 28, 2023 AggigTANT GUPERVISOR ASSISTANT SUPERVISOR

img008.png

MOTIVATION	1	2	3	4	5	6	7
Assertiveness						/	
Independence							/
Resourcefulness							/

INTERPERSONAL AND PERSONAL ADJUSTMENT	1	2	3	4	5	6	7
Relationship with Peers and Co-workers (Team manship)							/
Relationship with Superiors, Employers and Authority Figures (Deference)						/	
Self-esteem							/
Aggressive Tendencies		/					

GOAL-ORIENTATION	1	2	3	4	5	6	7
Directs one's effort towards clear cut objectives						/	

I. **CONCLUSION/REMARKS:**

(/) RECOMMENDED

No significant personality problems noted at the time of evaluation.

( ) FOR FURTHER EVALUATION

LEGEND:

1- Very Low
2- Low
3- Low Average
4- Average
5- High Average
6- High
7- Very High

DR.TIM VANDALSS
Psychologist

MFOWS-Annex G-Psychological Evaluation Form
Revision 02
12/08/2014
Page 2 of 2

img008.txt

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img002.txt                                    *img008.txt

MOTIVATION

Assertiveness

Independence

Resourcefulness

NIN

INTERPERSONAL
AND PERSONAL
ADJUSTMENT

Relationship with Peers
and Co-workers (Team
manship)

Relationship with
Superiors,Employers
and Authority Figures
(Deference)

Self-esteem

Aggressive Tendencies

GOAL-
ORIENTATION

Directs one's effort
towards clear cut
objectives

I. CONCLUSION/REMARKS:

(4) RECOMMENDED

No significant personality problems noted at the time of evaluation.

( ) FOR FURTHER EVALUATION

LEGEND

1- Very Low

2- Low

3- Low Average
4- Average

5- High Average
6- High
7- Very High

Psychologist

DRTIM VANDALSS

MFOWS-Annex G-Psychological Evaluation Form

Revision.02
12/08/2014

Page 2 of 2

Plain Text  Tab Width: 8  Ln 8, Col 1  INS
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List of mistaken text:

Error	Correct	Error	Correct
DRTIM	DR. TIM		
VANDALSS	HANDALSS		

Unlocking Tesseract OCR's Potential

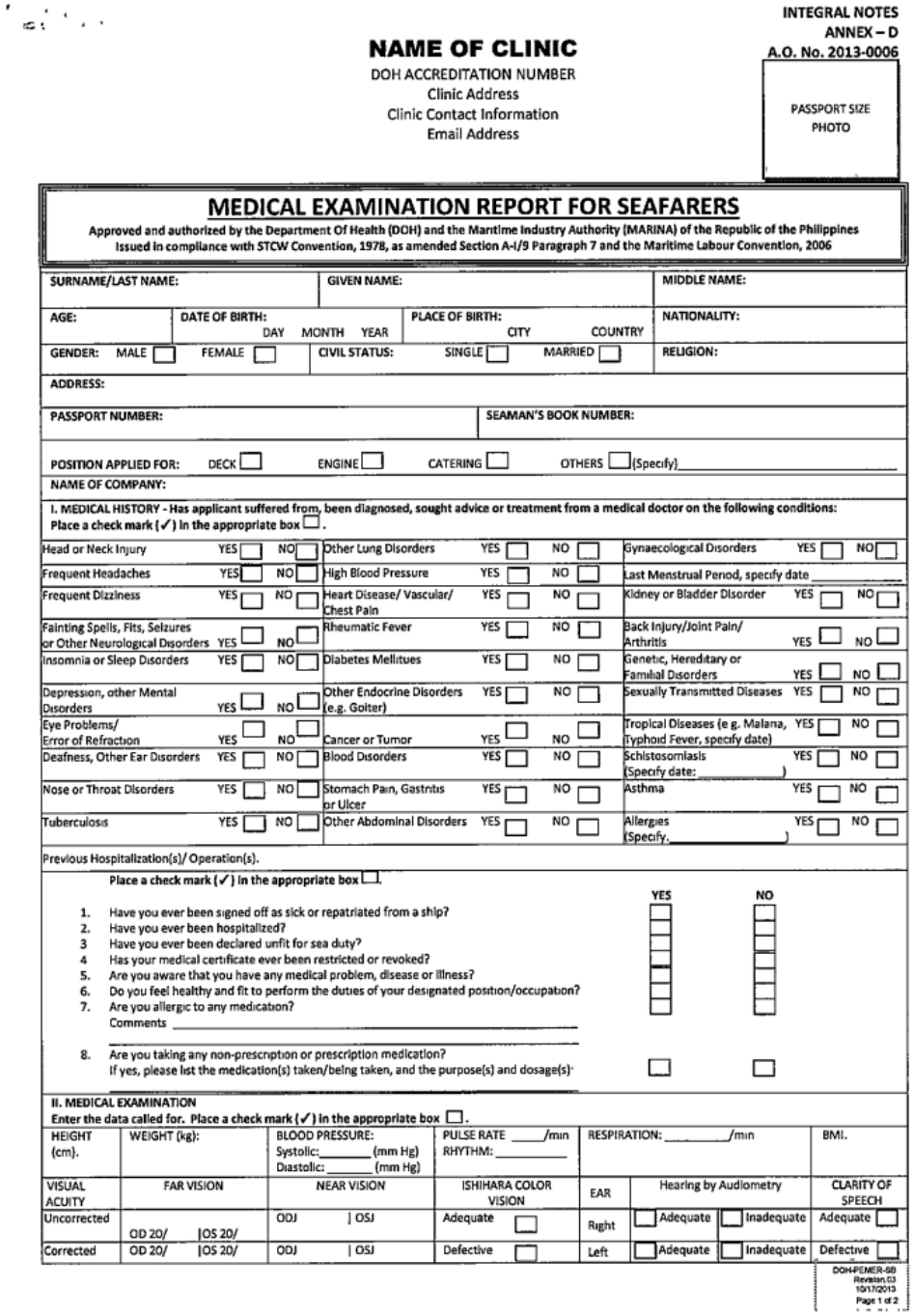
Our observations reveal that Tesseract OCR, while a powerful tool, can be sensitive to image quality, resulting in inaccuracies, especially with unclear images. Intricate characters like 'O,' 'D,' and 'P' are sometimes misinterpreted, and small letter 'L' and capital letter 'i' are occasionally confused. Moreover, it's crucial to ensure that handwritten characters are well-formed and clear as well to recognize them accurately.

To harness Tesseract's full potential, we recommend combining it with complementary libraries such as OpenCV, ImageMagick, or Pillow, which can enhance image preprocessing and overall accuracy. By addressing image quality and using Tesseract in conjunction with these libraries, users can significantly improve the precision and reliability of optical character recognition tasks.

Remember, Tesseract OCR, when coupled with the right tools and best practices, can provide exceptional results in text recognition, making it a valuable asset in various applications.

Finally, there are other OCR options available, each with its unique strengths for specific projects and it's advisable to explore alternative OCR tools and assess which one best suits your needs to ensure the highest level of accuracy and efficiency.

DOH Forms



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:	GIVEN NAME:	MIDDLE NAME:
AGE:	DATE OF BIRTH: DAY MONTH YEAR / PLACE OF BIRTH: CITY COUNTRY	NATIONALITY:
GENDER: MALE ☐ FEMALE ☐	CIVIL STATUS: SINGLE ☐ MARRIED ☐	RELIGION:
ADDRESS:		
PASSPORT NUMBER:	SEAMAN'S BOOK NUMBER:	
POSITION APPLIED FOR: DECK ☐ ENGINE ☐ CATERING ☐ OTHERS ☐ (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 ☐ 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).	WEIGHT (kg):	BLOOD PRESSURE: Systolic:_____ (mm Hg) Diastolic:_____ (mm Hg)	PULSE RATE _____/min RHYTHM: _____	RESPIRATION: _____/min	BMI.

VISUAL ACUITY	FAR VISION	NEAR VISION	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 ☐

DOH-PEMER-SD
Revision 03
10/17/2013
Page 1 of 2

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:
DAY MONTH YEAR	DAY MONTH YEAR	

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN: _____

LICENSE NUMBER: _____

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 (_____).

_____ _____

NAME AND SIGNATURE OF SEAFARER **DATE**

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

***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)*

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ANNEX – I
A.O. No. 2013-0006

NAME OF CLINIC
Address
Contact Information
E-mail address

HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING TEST CERTIFICATE

This is to certify that Mr./Ms._____
has undergone screening test for HIV/Acquired Immunodeficiency Syndrome (AIDS), and was found to be **Non-Reactive*/Reactive*** based on laboratory test (HIV-1/HIV-2).

Picture

_____
Examining Physician
License No._____
Date of Medical Examination _____

LABORATORY REPORT

Date: _____

Name: _____ Age: _____ Sex: _____ Civil Status: _____

Address: _____

Human Immunodeficiency Virus Types I (HIV-I) and (HIV-2) as a screening test for HIV/AIDS:

Screening Test Used: (please check)

- ☐ RAPID
- ☐ Particle Agglutination
- ☐ EIA / CMIA / ELFA
- ☐ Others (specify) _____

RESULT * **NONREACTIVE** ☐ **REACTIVE** ☐

_____
Medical Technologist
HIV Proficiency Cert. No._____
Expiry date _____

_____
Pathologist

**A non-reactive result indicates that the tested sample does not contain detectable Human Immunodeficiency Virus (HIV) antibody. This does not preclude the possibility of recent exposure to an infection by HIV.*

MFOWS-Annex I-HIVST
Revision:01
06/08/2011

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

NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL EXAMINATION REPORT FOR LANDBASED OVERSEAS WORKERS

Approved and authorized by the Department Of Health (DOH)

SURNAME/LAST NAME:	GIVEN NAME:	MIDDLE NAME:
AGE: / DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH: CITY COUNTRY	NATIONALITY:
GENDER: MALE ☐ FEMALE ☐	CIVIL STATUS: SINGLE ☐ MARRIED ☐	RELIGION:
ADDRESS:		
PASSPORT NUMBER:	COUNTRY OF DESTINATION:	
POSITION APPLIED FOR:	NAME OF COMPANY/ EMPLOYER/ RECRUITMENT AGENCY (WHENEVER APPLICABLE):	

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 ☐
						Operation(s) (Specify)	YES ☐	NO ☐

Place a check mark (✓) in the appropriate box ☐.

		YES	NO
1.	Have you ever been signed off as sick or repatriated from a jobsite overseas?	☐	☐
2.	Have you ever been hospitalized?	☐	☐
3.	Have you ever been declared unfit for work overseas?	☐	☐
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): _____	☐	☐

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

II. MEDICAL EXAMINATION
Enter the data called for. Place a check mark (✓) in the appropriate box ☐. Alongside columns A, B, C, put a check mark (✓) under 'YES' if Normal. If not Normal, specify findings.

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

VISUAL ACUITY	FAR VISION	NEAR VISION	ISHIHARA COLOR VISION (when required)	EAR	HEARING (Conversational or by Audiometry when required)		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 ☐

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: ☐ Reactive ☐ Non-Reactive (when required)
B. ECG: (for ≥ 40 y/o) ☐ Normal ☐ With Findings	E. STOOL EXAM: (when required) ☐ Normal ☐ With Findings	H. RPR and/or: ☐ Reactive ☐ Non-Reactive TPHA
C. CBC: ☐ Normal ☐ With Findings	F. Hepatitis B: (when required) ☐ Reactive ☐ Non-Reactive	I. BLOOD TYPE (Specify):

PSYCHOLOGICAL TEST: ☐ 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
Host Country Medical and Laboratory Requirements:	☐ PASSED	☐ WITH SIGNIFICANT FINDINGS

V. ASSESSMENT OF FITNESS FOR LANDBASED OVERSEAS WORK. 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 ☐ **UNFIT** ☐

DATE OF MEDICAL EXAMINATION: DAY MONTH YEAR	DATE OF EXPIRATION OF MEDICAL EXAMINATION REPORT: (Filling out this field is not mandatory.) DAY MONTH YEAR	MEDICAL EXAMINATION REPORT NO:

NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN:_____
LICENSE NUMBER: _____
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, POEA, my employer and _____.
(Name of Clinic)

_____ _____
NAME AND SIGNATURE OF APPLICANT **DATE**
THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN

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ANNEX – C
A.O. No. 2013-0006

NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL CERTIFICATE FOR LANDBASED OVERSEAS WORKERS

Approved and authorized by the Department of Health (DOH)

SURNAME/LAST NAME:	GIVEN NAME:		MIDDLE NAME
AGE:	DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH:	NATIONALITY:
GENDER: MALE ☐ FEMALE ☐	CIVIL STATUS: SINGLE ☐ MARRIED ☐		RELIGION:
ADDRESS:			
PASSPORT NUMBER:	COUNTRY OF DESTINATION:		
POSITION APPLIED FOR:	EMPLOYER/COMPANY/RECRUITMENT AGENCY (IF APPLICABLE):		

SATISFACTORY HEARING?	YES ☐	NO ☐
SATISFACTORY SIGHT?	YES ☐	NO ☐
SATISFACTORY COLOR VISION? (WHEN REQUIRED)	YES ☐	NO ☐
SATISFACTORY PSYCHOLOGICAL TEST?	YES ☐	NO ☐
IS APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY LANDBASED OVERSEAS WORK OR TO RENDER THE APPLICANT UNFIT FOR SUCH SERVICE OR TO ENDANGER THE HEALTH OF OTHER PERSONS?	YES ☐	NO ☐

PHOTO
(MUG SHOT)
PASSPORT SIZE

OFFICIAL STAMP

THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO:

_____
(NAME OF APPPLICANT)

RESULT:
FIT ☐ UNFIT ☐

_____
Name and Signature of Examining/Authorized Physician

Date of Examination: _____

Approved by:

_____
Medical Director

I HAVE READ AND UNDERSTOOD THE CONTENTS OF THE ABOVE AND THE INTEGRAL NOTES HEREOF.

APPLICANT'S NAME AND SIGNATURE: _____ **DATE:** _____
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

DATE OF ISSUANCE OF PEME CERTIFICATE: DAY MONTH YEAR	**DATE OF EXPIRATION OF PEME CERTIFICATE:** (Filling out this field is not mandatory.) DAY MONTH YEAR

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Republic of the Philippines
Department of Health
HEALTH FACILITIES AND SERVICES REGULATORY BUREAU

ANNEX-G
A.O. No. 2013-0006

TABULATED PSYCHOLOGICAL EVALUATION FORM

Name:
Position Applied for:
Referred by:
Date of Examination:

TEST ADMINISTERED
Intelligence Test (IQ):
Personality Test:
Others:

I. **INTELLECTUAL LEVEL**:

( ) Very Superior ( ) Average ( ) Mentally Deficient

( ) Superior ( ) Below Average

( ) Above Average ( ) Borderline

II. PERSONALITY TRAITS AND CHARACTERISTICS:

SENSE OF RESPONSIBILITY	1 Very Low	2 Low	3 Low Average	4 Average	5 High Average	6 High	7 Very High
Perseverance							
Obedience							
Self-discipline/Orderly							
Enthusiasm							
Initiative							

EMOTIONAL STABILITY	1	2	3	4	5	6	7
Can withstand boredom and work alone							
Tolerance to stress, pressures and inconveniences							
Faces reality							
Confidence							
Relaxed							

OBJECTIVITY	1	2	3	4	5	6	7
Tough-mindedness							
Adaptability							
Practicality							

MOTIVATION	1	2	3	4	5	6	7
Assertiveness							
Independence							
Resourcefulness							

INTERPERSONAL AND PERSONAL ADJUSTMENT	1	2	3	4	5	6	7
Relationship with Peers and Co-workers (Team manship)							
Relationship with Superiors,Employers and Authority Figures (Deference)							
Self-esteem							
Aggressive Tendencies							

GOAL-ORIENTATION	1	2	3	4	5	6	7
Directs one's effort towards clear cut objectives							

I. CONCLUSION/REMARKS:

( ) **RECOMMENDED**

No significant personality problems noted at the time of evaluation.

( ) **FOR FURTHER EVALUATION**

LEGEND:

1- Very Low
2- Low
3- Low Average
4- Average
5- High Average
6- High
7- Very High

_____
Psychologist

ANNEX – D
A. O. No. 2013-0006

NAME OF CLINIC

DOH ACCREDITATION NUMBER
Clinic Address
Clinic Contact Information
Email Address

MEDICAL CERTIFICATE FOR SERVICE AT SEA

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:		**GIVEN/FIRST NAME:**	**MIDDLE NAME:**
AGE:	DATE OF BIRTH: DAY MONTH YEAR	PLACE OF BIRTH:	NATIONALITY:
GENDER. MALE ☐ FEMALE ☐	CIVIL STATUS: SINGLE ☐ MARRIED ☐		RELIGION:
ADDRESS			
PASSPORT NUMBER:		SEAMAN'S BOOK NUMBER.	
POSITION ON BOARD: DECK ☐ ENGINE ☐ CATERING ☐ OTHERS ☐ SPECIFY_____			COMPANY:

DECLARATION OF THE AUTHORIZED PHYSICIAN

CONFIRMATION THAT IDENTIFICATION DOCUMENTS WERE CHECKED AT THE POINT OF EXAMINATION·	YES ☐	NO ☐
HEARING MEETS THE STANDARDS IN STCW CODE, SECTION A-1/9?	YES ☐	NO ☐
UNAIDED HEARING SATISFACTORY?	YES ☐	NO ☐
VISUAL ACUITY MEETS STANDARDS IN STCW CODE, SECTION A-I/9?	YES ☐	NO ☐
COLOUR VISION MEETS STANDARDS IN STCW CODE, SECTION A-I/9? Date of last colour vision test: (Day/ Month/ Year) _____/_____/_____	Y ES ☐	NO ☐
VISUAL AIDS (tick if worn) SPECTACLES ☐ CONTACT LENSES ☐		
FIT FOR LOOKOUT DUTIES?	YES ☐	NO ☐
NO LIMITATIONS OR RESTRICTIONS ON FITNESS? If "NO" specify limitations or restrictions·	YES ☐	NO ☐
IS APPLICANT SUFFERING FROM ANY MEDICAL CONDITION LIKELY TO BE AGGRAVATED BY SERVICE AT SEA OR TO RENDER THE SEAFARER UNFIT FOR SUCH SERVICE OR TO ENDANGER THE HEALTH OF OTHER PERSONS ON BOARD?	YES ☐	NO ☐

PHOTO (MUG SHOT) PASSPORT SIZE	THIS IS TO CERTIFY THAT A MEDICAL AND PHYSICAL EXAMINATION WAS GIVEN TO _____ (NAME OF SEAFARER) RESULT: FIT FOR DUTY. ☐ UNFIT FOR DUTY ☐ _____ NAME AND SIGNATURE OF EXAMINING/AUTHORIZED PHYSICIAN DATE OF EXAMINATION DAY/MONTH/YEAR _____/_____/_____ APPROVED BY· _____ MEDICAL DIRECTOR
OFFICIAL STAMP	NAME OF ISSUING AUTHORITY. _____ ADDRESS. _____ PHYSICIAN'S CERTIFYING AUTHORITY. _____ PHYSICIAN'S LICENSE NUMBER: _____

I HAVE READ AND UNDERSTOOD AND WAS INFORMED OF THE CONTENTS OF THE CERTIFICATEAND OF THE RIGHT TO A REVIEW IN ACCORDANCE WITH PARAGRAPH 6 OF SECTION A-I/9 OF THE STCW CODE.

SEAFARER'S NAME AND SIGNATURE: _____ **DATE:** _____
(THIS SIGNATURE SHOULD BE AFFIXED IN THE PRESENCE OF THE EXAMINING PHYSICIAN)

DATE OF ISSUANCE:DAY/ MONTH/ YEAR	**DATE OF EXPIRATION:** DAY/ MONTH/ YEAR

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