



THE REPUBLIC OF PANAMA  
PANAMA MARITIME AUTHORITY  
APPLICATION FORM FOR MEDICAL EXAMINATION

Surname GIGATO	First Name(s) ALLAN LOU	Middle Name GELLANGALA	Sex M	Age 23	Weight 58.8Kgs	Grade of the Officer ENGINE CADET
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MEDICAL HISTORY: Do any of the medical conditions listed below apply? Indicate additional comments on Section 33 below.

1. Loss of Vision	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	6. Hypertension	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	11. Epilepsy Attacks	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
2. Color Blindness	<input type="checkbox"/> <input checked="" type="checkbox"/>	7. Chest Pains	<input type="checkbox"/> <input checked="" type="checkbox"/>	12. Kidney Disease	<input type="checkbox"/> <input checked="" type="checkbox"/>
3. Seizures	<input type="checkbox"/> <input checked="" type="checkbox"/>	8. Diabetes	<input type="checkbox"/> <input checked="" type="checkbox"/>	13. Venereal Disease	<input type="checkbox"/> <input checked="" type="checkbox"/>
4. Frequent Headaches	<input type="checkbox"/> <input checked="" type="checkbox"/>	9. Shortness of Breath	<input type="checkbox"/> <input checked="" type="checkbox"/>	14. Narcotics History	<input type="checkbox"/> <input checked="" type="checkbox"/>
5. Heart Problems	<input type="checkbox"/> <input checked="" type="checkbox"/>	10. Tuberculosis	<input type="checkbox"/> <input checked="" type="checkbox"/>	15. Other Illness	<input type="checkbox"/> <input checked="" type="checkbox"/>

CLINICAL EVALUATION:

Notes: Describe every abnormality and enter pertinent item number before each comment on Section 33 below.

16. Head	Normal Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	20. Genito - Urinary (Hematuria / Pyuria)	Normal Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
17. Chest and Lungs	<input checked="" type="checkbox"/> <input type="checkbox"/>	21. Rectum (Blood / Masses)	<input checked="" type="checkbox"/> <input type="checkbox"/>
18. Vascular System	<input checked="" type="checkbox"/> <input type="checkbox"/>	22. Lower Extremities (Varicosities)	<input checked="" type="checkbox"/> <input type="checkbox"/>
19. Abdomen and Viscera	<input checked="" type="checkbox"/> <input type="checkbox"/>	23. Appearance and Mental State	<input checked="" type="checkbox"/> <input type="checkbox"/>

24. VISION	25. COLOR PERCEPTION	26. HEARING
Right Eye Uncorrected 20/ 20 Corrected 20/ 20	Book <input checked="" type="checkbox"/> Lantern <input type="checkbox"/> Yellow <u>normal</u> Red <u>normal</u> Green <u>normal</u> Blue <u>normal</u>	Right Ear <u>normal</u> Left Ear <u>normal</u>

27. BLOOD PRESSURE	28. RESPIRATION / MIN	29. PULSE
Systolic 110 Diastolic 80	20/min	Rate 85/min Regular <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

LABORATORY FINDING:

30. Chest Radiography X-Ray Report:	NORMAL CHEST FINDINGS	
31. URINALYSIS: Specific Gravity 1.020	Albumin negative	Sugar negative
	VDRL: Positive <input type="checkbox"/>	Negative <input checked="" type="checkbox"/>

MEDICAL REQUIREMENTS

(a) Applicants who have a Medical History of past or present epilepsy, acute venereal disease, neurosyphilis, varicose veins or use of narcotics or other diseases according to medical criterion will be disqualified.

(b) CLINICAL EVALUATION:

b.1. Vision Requirements for:

	DECK OFFICERS	ENGINEER OFFICERS	RADIO OFFICERS
COLOR	Perfect Color Perception	Able to Perceive Red, Yellow, and Green	
Uncorrected Both Eyes, at least	20/100	20/100	20/100
Corrected One Eye, at least	20/20	20/30	20/30
Corrected Other Eye, at least	20/40	20/50	20/50

b.2. Severely impaired hearing will disqualify the applicant.

b.3. Taking age into consideration, the applicants must have normal blood pressure and good general physical condition as found in the Clinical Evaluation.

(c) LABORATORY FINDINGS:

The Laboratory Findings must confirm satisfactory general physical conditions.

33. COMMENTS ON MEDICAL HISTORY AND CLINICAL EVALUATION

**FIT TO WORK**

REMARKS, according to Medical Requirements.

Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. Check the limiting Medical condition and list the disqualifying defect by item number.

(a) ☐ (b) ☐ (c) ☐ defect by item number

NAME OF EXAMINING PHYSICIAN CECIL ANN B. CHING, M.D.	ADDRESS OF THE MEDICAL CENTER 3rd Flr Marc bldg., 1971 Taft Ave. Malate Manila
Telephone: 536-5289	Fax: 536-5280

NAME OF MEDICAL CENTER MICAH MEDICAL CLINIC	License No. 58005	Date D 27 M 12 YR 85
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Is the applicant Physically Qualified according to the Medical Requirements? Yes ☒ No ☐

Date 17 Nov 2006

Signature and Seal of Examining Physician

IMPORTANT NOTICE:

This application form shall not be considered valid for the Insurance of the Certificate of Competency Examination confirmation for Merchant Seafarers Aboard Panamanian Vessels, if it does not comply with any of the following requirements:

- The lack of address, telephone number, stamp and/or signature of the physician.
- Incorrectly filled out or the lack of any of the laboratory tests indicated in the form.