Name (last, first, middle): _____

Date of birth (day/month/year): ___ / ___ / ___

Sex: ☐ Male ☐ Female

Home address: _____

Method of confirmation of identity, e.g. Passport No./Seafarer's book No. or other relevant identity document No.: _____

Department (deck/engine/radio/food handling/other): _____

Routine and emergency duties (if known): _____

Type of ship (e.g. container, tanker, passenger): _____

Trade area (e.g. coastal, tropical, worldwide): _____

Examinee's personal declaration (Assistance should be offered by medical staff)

Have you ever had any of the following conditions?

Condition		Yes	No
1.	Eye/vision problem	☐	☐
2.	High blood pressure	☐	☐
3.	Heart/vascular disease	☐	☐
4.	Heart surgery	☐	☐
5.	Varicose veins/piles	☐	☐
6.	Asthma/bronchitis	☐	☐
7.	Blood disorder	☐	☐
8.	Diabetes	☐	☐
9.	Thyroid problem	☐	☐
10.	Digestive disorder	☐	☐
11.	Kidney problem	☐	☐
12.	Skin problem	☐	☐
13.	Allergies	☐	☐
14.	Infectious/contagious diseases	☐	☐
15.	Hernia	☐	☐
16.	Genital disorder	☐	☐
17.	Pregnancy	☐	☐
18.	Sleep problem	☐	☐
19.	Do you smoke, use alcohol or drugs?	☐	☐

Condition		Yes	No
20.	Operation/surgery	☐	☐
21.	Epilepsy/seizures	☐	☐
22.	Dizziness/fainting	☐	☐
23.	Loss of consciousness	☐	☐
24.	Psychiatric problems	☐	☐
25.	Depression	☐	☐
26.	Attempted suicide	☐	☐
27.	Loss of memory	☐	☐
28.	Balance problem	☐	☐
29.	Severe headaches	☐	☐
30.	Ear (hearing, tinnitus)/nose/throat problem	☐	☐
31.	Restricted mobility	☐	☐
32.	Back or joint problem	☐	☐
33.	Amputation	☐	☐
34.	Fractures/dislocations	☐	☐

If you answered "yes" to any of the above questions, please give details:

Additional questions		Yes	No
35.	Have you ever been signed off as sick or repatriated from a ship?	☐	☐
36.	Have you ever been hospitalized?	☐	☐
37.	Have you ever been declared unfit for sea duty?	☐	☐
38.	Has your medical certificate even been restricted or revoked?	☐	☐
39.	Are you aware that you have any medical problems, diseases or illnesses?	☐	☐
40.	Do you feel healthy and fit to perform the duties of your designated position/occupation?	☐	☐
41.	Are you allergic to any medication?	☐	☐

Comments:

Additional questions		Yes	No
42.	Are you taking any non-prescription or prescription medications?	☐	☐

If yes, please list the medications taken, and the purpose(s) and dosage(s):

Name: _____

I hereby certify that the personal declaration above is a true statement to the best of my knowledge.

Signature of examinee: _____ Date (day/month/year): ___ / ___ / ___

Witnessed by (signature): _____ Name (typed or printed): _____

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr _____ (the approved medical practitioner).

Signature of examinee: _____ Date (day/month/year): ___ / ___ / ___

Witnessed by (signature): _____ Name (typed or printed): _____

Date and contact details for previous medical examination (if known):

_____

Medical examination

Sight

Use of glasses or contact lenses: Yes/No (if yes, specify which type and for what purpose)

_____

Visual acuity

	Unaided			Aided		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant						
Near						

Visual fields

	Normal	Defective
Right eye		
Left eye		

Colour vision

☐ Not tested	☐ Normal	☐ Doubtful	☐ Defective

Hearing

	Pure tone and audiometry (threshold values in dB)			
	500 Hz	1'000 Hz	2'000 Hz	3'000 Hz
Right ear				
Left ear				

Speech and whisper test (metres)

	Normal	Whisper
Right ear		
Left ear		

Clinical findings

Height: _____ (cm) Weight: _____ (kg)

Pulse rate: _____ /(minute) Rhythm: _____

Blood pressure: Systolic: _____ (mm Hg) Diastolic: _____ (mm Hg)

Urinalysis: Glucose: _____ Protein: _____ Blood: _____

	Normal	Abnormal
Head		
Sinuses, nose, throat		
Mouth/teeth		
Ears (general)		
Tympanic membrane		
Eyes		
Ophthalmoscopy		
Pupils		
Eye movement		
Lungs and chest		
Breast examination		
Heart		
Skin		
Varicose veins		
Vascular (inc. pedal pulses)		
Abdomen and viscera		
Hernia		
Anus (not rectal exam)		
G-U system		
Upper and lower extremities		
Spine (C/S, T/S and L/S)		
Neurologic (full/brief)		
Psychiatric		
General appearance		

Chest X-ray

☐ Not performed ☐ Performed on (day/month/year): ____ / ____ / ____

Results:

Other diagnostic test(s) and result(s)

Test:	Result:

Medical practitioner's comments and assessment of fitness, with reasons for any limitations:

Assessment of fitness for service at sea

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	☐	☐	☐	☐

☐ Without restrictions ☐ With restrictions Visual aid required ☐ Yes ☐ No

Describe restrictions (e.g., specific position, type of ship, trade area)

Medical certificate's date of expiration (day/month/year): ___ / ___ / ___

Date medical certificate issued (day/month/year): ___ / ___ / ___

Number of medical certificate: _____

Signature of medical practitioner: _____

Medical practitioner information (name, license number, address):