PRE-SEA AND PERIODIC MEDICAL FITNESS EXAMINATIONS FORM FOR SEAFARERS

(In accordance with ILO /WHO D.2/ 1997 & STCW Reg I/9 and MLC Reg 1.2)

Family Name	
Given Names	
Date of birth (day/month/year)	
Sex:	Male Female Please encircle
Home address	
Seaman Service Book No.: Nationality:	
Type of ship (container, tanker, Bulk carrier, General cargo)	
Trade area (e.g., coastal, tropical, worldwide)	

A. EXAMINEE'S PERSONAL DECLARATION *(Assistance should be offered by medical* staff)

Have you ever had any of the following conditions?

Condition	Yes	No	Condition	Yes	No
1. Eye/vision problem	☐	☐	18. Sleep problems	☐	☐
2. High blood pressure	☐	☐	19. Do you smoke ?	☐	☐
3. Heart/vascular disease	☐	☐	20. Operation/surgery	☐	☐
4. Heart surgery	☐	☐	21. Epilepsy/seizures	☐	☐
5. Varicose veins	☐	☐	22. Dizziness/fainting	☐	☐
6. Asthma/bronchitis	☐	☐	23. Loss of consciousness	☐	☐
7. Blood disorder	☐	☐	24. Psychiatric problems	☐	☐
8. Diabetes	☐	☐	25. Depression	☐	☐
9. Thyroid problem	☐	☐	26. Attempted suicide	☐	☐
10. Digestive disorder	☐	☐	27. Loss of memory	☐	☐
11. Kidney problem	☐	☐	28. Balance problem	☐	☐
12. Skin problem	☐	☐	29. Severe headaches	☐	☐
13. Allergies	☐	☐	30. Ear/nose/throat problems	☐	☐
14. Infectious/contagious diseases	☐	☐	31. Restricted mobility	☐	☐
15. Hernia	☐	☐	32. Back problems	☐	☐
16. Genital disorders	☐	☐	33. Amputation	☐	☐
17. Pregnancy	☐	☐	34. Fractures/dislocations	☐	☐

If any of the above questions were answered "yes", 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 hospitalised?	☐	☐
37.	Have you ever been declared unfit for sea duty?	☐	☐
38.	Has your medical certificate ever 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 medications?	☐	☐
Comments:			
42.	Are you taking any non-prescription or prescription medications?	☐	☐
If yes, please list the medications taken and the purpose(s) and dosage(s)			

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 examiner).

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

Witnessed by: (Signature) ____________________ Name: (typed or printed) _________________

B. MEDICAL EXAMINATION

☐ Pre-sea ☐ Periodic ☐ Other

Sight as per section A-I/9:

	Visual acuity					
	Unaided			Aided		
	Right eye	Left eye	Bino-cular	Right eye	Left eye	Bino-cular
Distant						
Near						

	Visual fields	
	Normal	Defective
Right eye		
Left eye		

Colour vision as per section A-I/9: ☐ Normal ☐ Doubtful ☐ Defective

Date of last colour vision test: Date (day/month/year) _____/_____/_____

Hearing as per section A-I/9:

Pure tone and audio metry (threshold values in dB)

	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz
Right ear						
Left ear						

Speech and whisper test (metres)

	Normal	Whisper
Right ear		
Left ear		

Height cm	Weight kg
Pulse rate (/ minute)	Rhythm
Blood pressure Systolic mm Hg	Diastolic mm Hg
Urinalysis Glucose	Protein

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

Chest X-ray	☐ Not performed	☐ Normal	☐ Abnormal
	Performed on (day/month/year):		____ _/____ _/______
Results:			

Other diagnostic test(s) and result(s):

Test	Result					
Haemoglobin “Hb” *1				g/dl		
Sedimentation rate “SR” *1						mm/hr
Hepatitis B *3	HB (ab)	☐+ve	☐-ve	HB (ag)	☐+ve	☐-ve
Bacteriological stool test*4	☐not performed		☐negative		☐positive	
Parasitical stool test*5	☐not performed		☐negative		☐positive	
ECG *1						
HIV *2 (+ve or -ve)						
Medical examiner’s comments:						

*1 compulsory
*2 not compulsory
*3 required by the Company for all crew from endemic areas
*4 required by the Company for all food handlers
* 5 required by the Company for all food handlers from tropical climates

Status of vaccination records:	☐ satisfactory	☐ to be renewed	Details

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

Is the Seafarer free from any medical conditions 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
☐	☐

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

Action taken by medical examiner (e.g., referral):

Place of examination: ____________________ Date (day/month/year) _____/_____/_____

Certificate is valid 2 years from its issuance date or until Date (day/month/year) ____ /____ /____

Official stamp (also print name of medical examiner):

Signature of medical examiner: ____________________

Authorized by: ____
(Sign and stamp of Government Surveyor on behalf of competent authority)