OWN EMBLEM	REGISTERED NAME, ADDRESS AND CONTACT DETAILS OF MEDICAL PRACTITIONER

Serial No : ……

Photograph

MEDICAL FITNESS CERTIFICATE FOR SERVICE AT SEA

This certificate is issued in compliance with the requirements of the STCW Convention, 1978, as amended and the Maritime Labour Convention 2006.

This form shall be completed in BLOCK CAPITAL letters

PERSONAL DETAILS *(to be filled by the seafarer)*

Name (as in the passport)

First :
……
Middle :
……
Last :
……

DOB (day/month/year): …… Sex (male/female): …….

Home address:
……

……

Passport number: ……Nationality: …….

Department: …… Deck / Engine / Other (if other specify)

Type of ship: ……... Trading area:

……
Date: (day/month/year)

Signature of the seafarer: ……...

FOR DOCTOR'S USE

I confirm that identification documents were checked at the point of examination: YES / NO

MEDICAL HISTORY – 1 *(to be filled by the seafarer)*

Have you ever had any of the following conditions?	**YES**	**NO**
1. Eye / vision disorders		
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 disorders		
11. Kidney problems		
12. Skin disorders		
13. Allergies		
14. Infectious/contagious diseases		
15. Hernia		
16. Genital disorders		
17. Pregnancy		
18. Sleeping disorders		
19. Do you smoke, use alcohol or drugs?		
20. Under gone any Operations / Surgeries		
21. Epilepsy / Seizers		
22. Dizziness / Fainting		
23. Loss of consciousness		
24. Psychiatric disorders		
25. Depression		
26. Have you attempted suicide		
27. Loss of memory		
28. Imbalance situations		
29. Severe headache		
30. Ear (Hearing, tinnitus) / Nose / Throat disorders		
31. Restricted mobility		
32. Back or joint injuries / disorders		
33. Amputation		
34. Fractures / Dislocations		

If you have answered "YES" to any of the questions above, please specify:

MEDICAL HISTORY – 2 *(to be filled by the medical practitioner)*

	YES	NO
35. Have you ever been signed off from a ship due to illness or injury		
36. Have you ever been hospitalized?		
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 medication?		

If you have answered "YES" to any of the questions above, please specify:

MEDICAL HISTORY – 3 *(to be filled by the medical practitioner)*

	YES	NO
42. Are you taking any non-prescribed or prescribed medication?		

If you have answered "YES" to the question above, please specify including list of medications, purpose and dosages:

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

Signature of seafarer _____ Date (day/month/year):____/_____/____

Witnessed by (signature):_____Name (types 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 seafarer _____ Date (day/month/year):____/_____/____

Witnessed by (signature):_____Name:_____

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

MEDICAL EXAMINATION *(to be filled by the medical practitioner)*

1. **Visual aids**

Spectacles ☐ Contact lenses ☐
(if one of the above boxes is ticked, state the purpose)

……

2. **Visual acuity**

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

3. **Visual fields**

	Normal	Defective
Right eye		
Left eye		

4. **Colour vision**

Not tested ☐ Normal ☐ Doubtful ☐ Defective ☐

5. **Hearing**

	Pure tone and audiometry (threshold values in dB)			
	500 Hz	1000 Hz	2000 Hz	3000 Hz
Right ear				
Left ear				

6. **Speech and whisper test**

	Normal (m)	Whisper (m)
Right ear		
Left ear		

7. **Clinical findings**

Height : …….. (cm) Weight : …….(kg)

Pulse rate : ……..(per minute) Rhythm : …….

B/P – Systolic : ……(mm Hg) Diastolic : ……(mm Hg)

Urinalysis – Glucose : …… Protein : …… Blood : …….

	Normal	Abnormal
Head		
Sinuses, nose, throat		
Mouth/teeth		
Ears(general)		
Tympanic membrane		
Eyes		
Ophthalmoscope		
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

Date obtained (day/month/year) …….Result: …….

8. Other diagnostic test(s) and result(s)

Test	Results

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

9. Assessment of fitness for service at sea *(to be filled by the medical practitioner)*

Declaration of the recognized medical practitioner;

		Yes	No
1	Hearing meets the standards in STCW Code Section A-I/9?		
2	Unaided hearing satisfactory?		
3	Visual acuity meets the standards in STCW Code Section A-I/9?		
4	Colour vision meets the standards in STCW Code Section A-I/9? Date of last colour vision test:		
5	Is the seafarer free from any medical condition likely to be aggravated by service at sea or to render the seafarer unfit for such service or endanger the life of person onboard?		

On the basis of the seafarer's personal declaration, my clinical examination and the diagnostic test results recorded above, I declare the seafarer 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)

Date of issue (day/month/year): …….date of expiry:……
(Validity period :2 years for 18-55 years of age,1 year for 16-18 years and over 55 years of age)

I hereby confirm that the medical examination has been carried out in accordance with the ILO/IMO Guidelines on the Medical Examinations of Seafarers and the Merchant Shipping Regulations of the authorizing Administration.

I confirm that, I have been informed of the content of the certificate and of the right to review in accordance with the paragraph 6 of section A-I/9 STCW. Seafarer's signature: ……..	Medical practitioner information: (name, address, telephone number) Signature of medical practitioner: …….