OWN EMBLEM	REGISTERED NAME, ADRESS AND CONTACT DETAILS OF MEDICAL PRACTITIONING CENTRE

Serial No : ……

Photograph

MEDICAL FITNESS CERTIFICATE

This certificate is issued by the Democratic Socialist Republic of Sri Lanka in compliance with the requirements of section 127 (1) (i) of the Merchant Shipping Act, No 52 of 1971, and the Merchant Shipping (Training, Certification and Watchkeeping) Regulations No. 34 of 2013, concerning minimum medical fitness standards in merchant ships as equivalent to Medical Examination (Seafarers) Convention, 1946 (ILO No. 73 & No. 147) and STCW 78 as amended.

This form shall be competed in BLOCK CAPITAL letters

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

Name (as in the passport)

First : ……

Middle : ……

Last : ……

DOB : DD / MM / YYYY Sex : MALE / FEMALE

Home address: ……..

……

Passport number: …… Nationality: ……..

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

Type of ship: ……... Trading area: ……

Date: DD / MM / YYYY

Signature of the applicant: ……...

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 Doctor)*

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 Doctor)*

	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 Doctor)*

	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:

Date and the serial number of the previous medical examination (if known) :

…….

I hereby certify that the above declarations are true statements to the best of my knowledge and I authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr. ……. (name of the approved medical practitioner)

Date : DD / MM / YYYY Seafarer's signature : ……

Witnessed by (signature) : ……..

Name (typed / printed) : ……

MEDICAL EXAMINATION *(to be filled by the Doctor)*

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 : DD / MM / YYYY Results : …….

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

Test	Results

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

ASSESSMENT OF FITNESS FOR SERVICE AT SEA *(to be filled by the Doctor)*

On the basis of the seafarer's medical history, my clinical examination and the diagnostic test results recorded above, I declare the seafarer is not 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 onboard.

Hearing meets the standards in section A-I/9 of STCW : YES / NO

Unaided hearing satisfactory : YES / NO

Visual acuity meets the standards in section A-I/9 of STCW: YES / NO

Colour vision meets standards in section A-I/9 of STCW : YES / NO

Date of last colour vision test : DD / MM / YYYY

Fit for lookout duties : YES / NO

Fit for sea service without limitations ☐

Fit for sea service with limitations ☐

Not fit for sea service ☐

If fit for sea service with restrictions, describe the restrictions (specific rank, type of ship, trading area etc.)

Date of medical certificate issued : DD / MM / YYYY date of expiry : DD / MM / YYYY
(Validity period : two years from the date of issue)

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 : ……	DGMS approved medical practitioner's stamp (Name, address, telephone number):

Signature of the approved medical practitioner: ……..