

MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD

With the requirement of the STCW Convention, 1978 as amended and the Maritime Labour Convention 2006

SURNAME:			GIVEN NAME (S):		
DATE OF BIRTH: DAY MONTH YEAR			PLACE OF BIRTH CITY COUNTRY		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
POSITION ON BOARD: MASTER <input type="checkbox"/> DECK OFFICER <input type="checkbox"/> ENGINEERING OFFICER <input type="checkbox"/> RADIO OPERATOR <input type="checkbox"/> RATING <input type="checkbox"/>			MAILING ADDRESS OF APPLICANT:		
DECLARATION OF THE AUTHORIZED PHYSICIAN					
VISION			COLOR TEST TYPE		HEARING
	WITHOUT GLASSES	WITH GLASSES	<input type="checkbox"/> BOOK <input type="checkbox"/> LANTERN YELLOW _____ RED _____ GREEN _____ BLUE _____		RIGHT EAR _____
RIGHT EYE	_____	_____			LEFT EAR _____
LEFT EYE	_____	_____			
Confirmation that identification documents were checked at the point of examination: YES <input type="checkbox"/> NO <input type="checkbox"/>					
Hearing meets the standards in STCW Code, Section A-1/9? YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APLICABLE <input type="checkbox"/>					
Unaided hearing satisfactory? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Visual acuity meets standards in STCW Code, Section A-1/9? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Colour vision meets standards in STCW Code, Section A-1/9? YES <input type="checkbox"/> NO <input type="checkbox"/> (the visual test it is required every six years) Date of the last colour vision test: (Day/Month/Year) _____ / _____ / _____.					
Are glasses or contact lenses necessary to meet the required vision standards? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Able for watchkeeping? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Is applicant taking any non-prescription or prescription medications? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Is the seafarer free from any medical condition likely to be aggravated by service at sea or to render the seafarers unfit for such service or to endanger the health of other persons on board? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Hereby I declare that I am in knowledge of the contents of the Physical Examination.					
_____		_____		_____	
Signature of Applicant		Name of Applicant		Date	
CIRCLE APPROPRIATE CHOICE: (HE / SHE) IS FOUND TO BE (FIT / NOT FIT) FOR DUTY AS A (MASTER / DECK OFFICER / ENGINEERING OFFICER / RADIO OPERATOR / RATING) (WITHOUT ANY / WITH THE FOLLOWING) RESTRICTIONS: _____					
NAME AND DEGREE OF PHYSICIAN: _____					
ADDRESS: _____					
NAME OF PHYSICIAN'S CERTIFICATING AUTHORITY: _____					
DATE OF ISSUE PHYSICIAN'S CERTIFICATE: _____					
SIGNATURE OF PHYSICIAN: _____			STAMP OF PHYSICIAN: _____		DATE: _____
EXPIRY DATE OF CERTIFICATE: _____					