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Photo

# MEDICAL CERTIFICATE

Surname | Other Names | Position applied for

Date of Birth (DD MM YYYY) | Sex | Nationality | ID (Passport/Discharge book) No:

Ship Name

I have evaluated the above-named examinee according to ..... (national law, regulation or other requirement), and on the basis of the examinee's personal declaration, my clinical examination, and the diagnostic test results obtained, and in consideration of the essential requirements of the position applied for, in my opinion this employee **DOES / DOES NOT** meet the physical requirement for this job.

Restrictions applied: None/……

If unfit state reason

Visual aid required (specify) Yes/No Informed spares necessary Yes/No Fit for lookout duty Yes/No

Expiry date

Signed: Name:

Authorizing body: (Government/Maritime Administration) Clinic stamp:

Date: DD MM YYYY

I acknowledge that I have been advised of the content of the medical examination form.

Examinee's signature: .....

**A copy of this page should be kept by the examining physician.**
**The original should be given to the seafarer.**

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# MEDICAL EXAMINATION REPORT - STRICTLY CONFIDENTIAL

This examination must be carried out by an authorised physician. The seafarer must meet the minimum standards set down by the authorising body. Reference should also be made to the ILO and UK P & I Club PEME guidelines.

Surname

Other Names

Date of Birth

Sex

Position/Job Applied For

Home Address

Usual Medical Practitioner – Name/Address

Date/result of last medical examination:

Date/result of last PEME examination (if any):

## PRE-EMPLOYMENT QUESTIONNAIRE - PERSONAL MEDICAL HISTORY

**To be completed by the examining physician in consultation with the seafarer.**

**Vaccination status (This section is for information only. No vaccinations are required/authorized as part of this exam).**

Vaccination status (state date of last vaccination/immunity):

| | | | | |
|---|---|---|---|---|
| Diphtheria: | Tetanus: | Pertussis: | Polio: | Hepatitis A: |
| Typhoid : | Hepatitis B: | Yellow Fever: | MMR: | Varicella: |

**Advice given regarding vaccinations required: Yes/No**

To the best of your knowledge, have any of your family ever suffered from any of the following? Heart conditions/angina, Blood pressure problems, Stroke/vascular disease, Mental/nervous, disorder, Diabetes, Tuberculosis, Asthma/eczema, Glaucoma, Epilepsy/fits, Cancer, Anaemia

If yes, please give details:

Are you taking any non-prescription or prescription medications?
Please list with dosage, and reason for taking

Have you any allergies to medications, or to environmental allergens eg Hay Fever?

Do you smoke? Yes/No Number of cigarettes per day _____

Do you drink alcohol? Yes/No Number of units per week _____

Do you feel healthy and fit to perform the duties of your designated position/occupation? Yes/No

Have you ever been declared unfit for sea duty, or had your medical certificate restricted or revoked? Yes/No

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| Have you **ever** had any medical conditions affecting the systems below? | Y | N | If yes, give details: |
|---|---|---|---|
| Eye or vision problem: eg glaucoma, eye injury, glasses/ contact lenses | | | |
| Dental problems | | | |
| Ear/nose/throat problems: eg Ear Infections, Hearing Problems, Sinus Trouble, Recurrent Nose Bleeding, | | | |
| Heart problems: Rheumatic Fever, abnormal heart beat, Chest Pain, Heart Attack, Heart surgery | | | |
| Vascular disease: High blood pressure, Varicose veins, Poor Circulation | | | |
| Chest problems: Shortness of Breath, Coughing up Blood, Asthma/bronchitis, Wheezing, Pneumonia, Pleurisy, TB | | | |
| Endocrine or hormone disorders: Diabetes or blood sugar problems, Thyroid problem | | | |
| Malignant Diseases: Cancer or Tumour, Blood disorders | | | |
| Kidney problems: Urinary Infections, Blood in Urine, Kidney Stones | | | |
| Genital disorders: Sexually Transmitted Disease | | | |
| Males: Prostate Disease, Testicular lumps or swellings, Varicocele | | | |
| Females: Gynae problems, abnormal smears, painful periods, pregnancy problems, Breast lumps. | | | |
| Date of last menstrual period: (exclude Pregnancy) | | | |
| Skin problems: dermatitis, rashes, eczema, psoriasis | | | |
| Infectious/contagious diseases: Malaria or other tropical diseases, HIV / AIDS | | | |
| Digestive disorder: Frequent Indigestion, Gastric/Duodenal Ulcer, Abdominal Pain Diarrhoea, Constipation, Bleeding from gut, Jaundice, hepatitis or Liver Complaints, Hernia, Haemorrhoids/piles | | | |
| Neurological problems: Epilepsy, seizures or Blackouts, Dizziness/fainting, Loss of consciousness, Frequent Severe headaches or Migraines, Muscular Weakness or Paralysis, Tingling or Numbness, Balance problems, Stroke, Head Injury or Concussion, loss of memory. | | | |
| Psychiatric problems: Anxiety, Depression, Sleep problems, Nervous Breakdown, suicide attempt | | | |
| Restricted mobility: Back problems, Sciatica, Fractures, Dislocations, Severe Sprain, Arthritis, Rheumatism, Joint pain. | | | |

Apart from conditions as above, have you had **any** other Operations or surgery, Serious accidents or injuries, Medical problems, diseases or illnesses, visits to health care professionals or hospital admissions? Yes/No

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I certify that the above medical information is true and any false information provided will be grounds for immediate dismissal. Any failure to disclose any pre-existing medical condition will be grounds to exclude claims for any illness/injury and other benefits to which I might otherwise be entitled. The details of my medical examination may be released to my own doctor and also the results may be communicated to the personnel department of the company/UK Club for whom this examination is carried out.

I hereby authorize the release of all my previous medical records from any health professionals, health institutions and public authorities to Dr……..……

Signed: (Applicant) Witness: Date: DD MM YYYY

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## Physical Examination

| Height (cm) | Weight (kg) | BMI (kg/m²) | | Rate | Rhythm | | Systolic | Diastolic |
|---|---|---|---|---|---|---|---|---|
| | | | Pulse | | | Blood Pressure | | |

| Vision | Distance (Snellen chart) | | |
|---|---|---|---|
| Unaided | R 6/ | L 6/ | Both 6/ |
| Aided | R 6/ | L 6/ | Both 6/ |
| | Near (Sloan letters) | | |
| Unaided | R N | L N | Both N |
| Aided | R N | L N | Both N |

| Audiogram | right ear | | | | | |
|---|---|---|---|---|---|---|
| Khz | 500 | 1,000 | 2,000 | 4,000 | 6,000 | 8,000 |
| dB | | | | | | |
| | left ear | | | | | |
| Khz | 500 | 1,000 | 2,000 | 4,000 | 6,000 | 8,000 |
| dB | | | | | | |

| Ishihara | Normal/Abnormal | Visual fields | Normal/Abnormal |
|---|---|---|---|
| | | | |

| Whisper test | R | cm | L | cm |
|---|---|---|---|---|
| | | | | |

| Lung Function | PEFR | | FEV1 | | FVC | |
|---|---|---|---|---|---|---|
| | | | | | | |

| | Glucose | Protein | Blood |
|---|---|---|---|
| Urinalysis (+/-) | | | |

### Systems examination

| | Normal/Abnormal (give detail) | | Normal/Abnormal (give detail) |
|---|---|---|---|
| General appearance | | Vascular (inc. pedal pulses) | |
| Eyes, pupils | | Varicose veins | |
| External Ocular Movements | | Abdomen, inc Hernial orifices | |
| Opthalmoscopy | | Genito-urinary(Not Pelvic Exam) | |
| Ear, inc Tympanic Membrane | | Anus, (Not Rectal Exam) | |
| Nose | | Musculo-skeletal | |
| Throat | | Spine – Cervical, thoracic and lumbar | |
| Mouth, Teeth, speech | | CNS – inc general neuro exam | |
| Breast examination | | Lymphatic system | |
| Chest and lungs | | Skin | |
| Heart | | Mental capacity | |

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**Test Results**

| See guidelines for requirements for each test (** optional) | State whether applicable, Positive/Negative, Normal, or if abnormal give details |
|---|---|
| Chest X-Ray | |
| Electrocardiogram (only for individuals aged 50 and above, unless otherwise requested). | |
| Full Blood Count | |
| Urea, electrolytes, Creatinine, Glucose, LFTs | |
| Hepatitis A | |
| Hepatitis B – HBsAg, if positive other markers to establish infectivity | |
| Hepatitis C – anti HCV | |
| Syphilis serology VDRL/RPR | |
| HIV | |
| Drug & Alcohol screening ** | |
| Food handlers screening** | |
| Other: | |
| Other: | |

**Consent for HIV Test**

**(No HIV test may be conducted in the USA or where otherwise prohibited by applicable law)**

I declare that I am not a citizen or resident of the United States and that I am willing to undergo testing for HIV antibodies (AIDS test) and consent to the taking of a sample for this purpose. If the test proves positive, I agree to the results being passed on to my medical practitioner.

Signature..... Date.....

Witnessed by ..... Date.....

Fit/Temporarily unfit/Permanently unfit

Action required prior to certification, e.g. referral:
Review date:

Name of Doctor:

Signature of Doctor:

Authorising body:

Date of examination: DD MM YYYY

Name of examining Clinic/Hospital:

Clinic Stamp:

**The original of pages 2-5 should be kept by the examining physician, and a copy given to the seafarer.**