

MEDICAL CERTIFICATE FOR PERSONNEL SERVICE ON BOARD

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		
RIGHT EYE	_____	_____	<input type="checkbox"/> BOOK <input type="checkbox"/> LANTERN YELLOW _____ RED _____ GREEN _____ BLUE _____	RIGHT EAR _____
LEFT EYE	_____	_____		LEFT EAR _____
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: _____

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